



**End of Project Review of
“Social Marketing and Targeted Communications for
HIV and AIDS Prevention Among Most-at-Risk Populations in
Burma, China, Lao, and Thailand”
October 2007–September 2010**

Final Report

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Acronyms

AEM	Asian Epidemic Model
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Anti-Retroviral
BCC	Behavioral change communication
CA	Cooperating Agency
CBO	Community-based organization
CDC	Center for Disease Control
CHAS	Center for HIV/AIDS and STIs (Ministry of Health, Lao PDR)
CPP	Comprehensive Prevention Package
CPS	Comprehensive Package of Services
DiC	Drop-in center
FHI	Family Health International
FSW	Female sex worker
FY	Financial year
GFATM	The Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HPI	Health Policy Initiative
IDU	Injecting drug user
INGO	International Non-governmental organization
MARP	Most-at-risk population
MMT	Methadone maintenance therapy
MoH	Ministry of Health
MSM	Men who have sex with men
NSP	National Strategic Plan for HIV and AIDS
NCAIDS	National Center for AIDS and Infectious Diseases
NGO	Non-governmental organization
PHB	Public Health Bureau
PLHA	People living with HIV or AIDS
PE	Peer Educator
PSB	Public Security Bureau
PSI	Population Services International
RBT	Routine Behavioral Tracking
RDMA	Regional Development Mission, Asia
RMB (CNY)	Renminbi (Chinese currency)
SQH	Sun Quality Health (network of private providers in Burma)
STI	Sexually transmitted infections
TA	Technical assistance
TB	Tuberculosis
TOP	Targeted Outreach Program
TRaC	Tracking Results Continuously
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government

VCT
WHO

Voluntary counseling and testing
World Health Organization

Executive summary

This report details findings of an end of project assessment of the implementation of USAID/RDMA's cooperative agreement with PSI for 'Social marketing for STI/HIV prevention among high risk groups in the Mekong region, FY08-FY10. The project is funded over a three period, with allocations by country as follows – Burma: HIV \$3.6 m, TB \$1 m; China: \$2.6 m; Lao: \$1 m; and Thailand: \$0.2 m.

The strategic goal of the project is to reduce the spread of HIV and STI among most at risk populations (MARPs) including female sex workers (FSW) and their clients, injecting drug users (IDU), and men who have sex with men (MSM), including transgenders (TG). The project's main objective is to increase access to the Comprehensive Package of Services (CPS) by MARPs. Key achievements in relation to the project's intermediate objectives are as follows:

Objective 1: Increase access to prevention interventions for MARPs

All of the MARPs targeted by PSI are hard to reach because of social marginalization and all have relatively high rates of HIV, although this varies by MARP and geographic location. PSI's programs in each country have resulted in significantly increased access to prevention interventions by MARPs. Depth of penetration in accessing MARPs has been high.

PSI's social marketing activities have significantly grown the size of the condom markets and established condom buying habits among MARPs and others. Since 2007, sales and free distribution of condoms and lubricant to MARPs, their partners and the general population have continued to grow significantly. PSI recognizes the need to encourage new private sector entrants into the condom market, (which is occurring in Lao), to ensure long term sustainability, whilst ensuring that affordable condoms are available to the poor and most vulnerable.

Periodic behavioral surveys conducted by PSI in each country found evidence of positive behavior change in the most at risk populations targeted. These outcomes include higher levels of condom use and consistent condom use among MSM and FSW, and in China decreased sharing of needles and syringes among IDU. PSI behavioral data for most MARPs indicates that statistically significant levels of behavior change are achieved when MARPs are exposed to more elements of the comprehensive prevention package. This 'dosage' effect confirms that the comprehensive prevention package approach is both appropriate and needed.

Increased safe behavior by MARPs may contribute to the program's strategic goal of reducing the spread of HIV and STIs among MARPs. However, there is insufficient data at this point in time to demonstrate whether this higher level impact is being achieved by PSI.

Objective 2: Increase access to care and support for PLHA

PSI's promotion and provision of VCT services has increased access to HIV testing, enabling MARPs to know their HIV status and be referred to care, support and treatment services. However, the uptake of HIV counseling and testing is quite low, and most MARPs do not know their HIV status. PSI promotion and provision of STI diagnostic and treatment services for MARPs has increased access to client-friendly STI services. As with VCT, the uptake of STI clinical services has generally been low. This points to the need to address demand side issues as well as supply side issues. The introduction of rapid testing for VCT significantly increased VCT uptake among MARPs in China and Lao. PSI's social marketing of pre-packaged, branded STI

treatment kits through DiCs and the private sector has increased MARP access to appropriate and quality treatment regimens at an affordable price.

USAID support for PSI/Burma's TB program has increased access to free TB treatment on a national scale, with a focus on the poor. However, integration of HIV and TB has been limited as only a minority of TB cases are having HIV tests due to policy settings which limit the places where HIV testing can be performed.

Access by HIV positive MARPs to care, support and treatment services provided by PSI's partner organizations has been limited in some countries, particularly Burma, because of the small number of treatment places available. In high prevalence settings, PSI increased its focus on the care and support needs of PLHA. While there are linkages with care, support and treatment services, the capacity of all programs to ensure a seamless continuum of prevention to care, support and treatment has been insufficient.

Objective 3: Increase access to strategic information

PSI's strong emphasis on strategic information highlights the value the organization places on evidence-based programming; quality assurance methods are built into its data collection systems; good internal capacity has been built; and the results of research are turned into program action. Areas where performance has been mixed are in using strategic information for advocacy on policy change and program issues at the national and sub-national levels; more regular sharing and dissemination of results to external partners; and greater involvement of MARP communities in evidence-based decision making.

Objective 4: Strengthen the enabling environment

PSI's work has contributed to strengthening the enabling environment in a number of ways. There has been significant capacity building of the private sector in social marketing of condoms and other health products and in social franchising of health services to improve access by the poor. The capacity of MARPs to design and implement prevention programs has increased significantly in all countries. Capacity building of peers has resulted in a self-confidence that has reduced internalized or self-stigma and facilitated community mobilization. The capacity of PSI programs in all countries to ensure a seamless continuum of prevention to care, support and treatment needs continued strengthening.

PSI's approach has been to foster peer led community mobilization approaches in its work with MARPs. As an INGO, PSI has been able to more readily work with marginalized community groups than would be the case for local organizations in the context of government antipathy towards civil society. The provision of high profile HIV services for MARPs has resulted in the health and broader social needs of MARPs becoming more visible to local and national health officials and other partners, which has helped to combat stigma and discrimination and further MARP visibility in national strategies and Global Fund proposals. Where PSI prevention programs have had a strong focus on the needs of PLHA, particularly in Burma, this has resulted in a more open and supportive environment for PLHA, which helps to reduce stigma faced by PLHA from their MARP peers.

Other overarching findings are:

Innovation has been a strong feature of PSI's programming in all countries. This has included use of financial incentives to reach program targets, promotion of female condoms to MSM, use of

information technologies to promote VCT, use of peer progression promotion structures for prevention program staff, and use of GIS technology for measuring program coverage in relation to hot-spots. Innovation has also been a strong feature of PSI's approach to strategic information. This includes the development of client unique identifier codes to facilitate measurement of the number of individuals reached and periodic surveys to track behaviors and the determinants of behavior which are then used to refine interventions and BCC messaging. Innovative use of social franchising has also been a strong feature of PSI's work.

PSI has been very successful in **leveraging other donor funds** for HIV and other public health work. Leverage of funds has allowed an expansion of USAID-developed models, resulting in greater access by MARPs to prevention interventions and care, support and treatment. Additional funding has enabled PSI to develop a portfolio of other public health work which in turn has allowed for a more integrated approach such as with HIV/TB work.

Public health officials in the four countries are increasingly seeing the value of community led approaches to HIV prevention. However, the broader political environments in three of the four countries are not encouraging for the development of civil society. Considerable work remains to be done in documenting and advocating for this approach and in CBO organizational development.

PSI's social franchising of health services has good sustainability potential as it has been accompanied by ongoing capacity building of pharmacies, medical practitioners and community health workers.

Replication of PSI's programming has been occurring in a number of ways. As additional funds are mobilized from other donors, this has allowed PSI's existing programs to be replicated in new sites. The elements of USAID's Comprehensive Prevention Package model, being implemented by PSI, has also had a significant influence on the prevention programming of other donors and in the programming approach reflected in Global Fund proposals. More broadly, the HIV and AIDS National Strategic Plans of all four countries now prioritize MARPs and the prevention approaches in these strategies have been strongly influenced by the CPP. This type of replication significantly strengthens sustainability.

1. The context

1.1 Background

A review of PSI's cooperative agreement "Social Marketing for STI/HIV Prevention among High Risk Groups in the Mekong Region" (2007–2010) was carried out from 4 January to 5 February 2010.

The strategic goal of the project is to reduce the spread of HIV and STI among most at risk populations (MARPs) including female sex workers (FSW) and their clients, injecting drug users (IDU), and men who have sex with men (MSM), including transgenders (TG). The project's main objective is to increase access to the Comprehensive Package of Services (CPS) by MARPS. Four underlying objectives include:

1. Increase access to prevention interventions for MARPs
2. Increase access to care and support for PLHA
3. Increase access to strategic information
4. Strengthen the enabling environment

The project is funded over a three year period (FY2008–FY2010) and includes:

- Burma (HIV: \$3.6m: + TB: \$1m)
- China (\$2.6m)
- Lao (\$1m)
- Thailand (\$0.2m)

The key objective of this review of USAID/RDMA's cooperative agreement with PSI was to determine the strengths and weaknesses of the program in order to inform the USAID Regional Development Mission's Asia (RDMA) program planning and design of future HIV technical capacity building activities in non-presence countries in Asia. The primary focus of the assessment was on the USAID-supported activities of PSI. However, as PSI works with other USAID Cooperating Agencies (CAs), the assessment also examined the work of PSI and other CAs in STI and HIV prevention and social marketing activities in Burma, China, Lao PDR and Thailand related to PSI's current activities as well as activities in Thailand that were initially funded through the agreement and were later transitioned (MSM/TG) or discontinued (IDU).

The Scope of Work (SOW) for the assessment set out the following primary areas for investigation:

1. Have country-level activities improved the quality of preventive products -- condoms, lubricant, sexually transmitted infection (STI) treatment kits -- available to MARPs?
2. Have country-level activities improved the availability and access for MARPs to these preventive products?
3. Have country-level activities helped to build the private sector's capacity to provide HIV/STI products for MARPS?
4. Have country-level activities built the capacity of private and/or public sector HIV/STI service providers (i.e. on voluntary HIV counseling and testing (VCT) provision, STI screening, STI treatment)?
5. Has PSI been actively engaged in participating in the development of best practice models on HIV/STI prevention, care, and support with national partners/stakeholders?
6. Has PSI been actively involved in supporting the country to mobilize funding to support the scale up and sustainability of interventions beyond USAID available funds?

7. Has PSI been actively participating in assisting the national program to ensure country-level activities are appropriately ‘following the epidemic’?

1.2 Methodology

Assessment activities began with a review of documents (scope of work, planning, reporting, program performance and technical documents) provided by USAID/RDMA and PSI. Information gained from the document review served as a basis to formulate questions for key informants including PSI project staff, government officials, project beneficiaries and other stakeholders.

The seven-person assessment team carried out site visits to PSI interventions in Burma, China, Lao and Thailand. The team was made up of three independent consultants and four USAID staff, three of whom work in USAID/RDMA. The team split up for site visits with one team visiting Burma and Lao, and the other team visiting China (Yunnan and Guangxi provinces) and Thailand. During the visits each team met with key informants including implementing partners, government officials, and project beneficiaries—female sex workers (FSW), injecting drug users (IDU), men who have sex with men (MSM), and transgenders (TG). Site visits were for the following durations:

- Lao PDR: 3 days
- Burma: 5 days
- China: 8 days
- Thailand: 1 day

Documents

A variety of documents from both PSI and USAID/RDMA were available for review (see Annex 1). Annual reports, work plans, proposals, trip reports, research reports, and site fact sheets from the project shed light on progress over time. Other materials provided information on HIV prevalence trends, HIV and AIDS services, social marketing of HIV prevention commodities, and behavior change communication strategies employed by PSI.

Data

Data available to the assessment team included data from PSI’s TRaC (Tracking Results Continuously) surveys which provided information on behaviors of MARPs, results of service delivery, and exposure to PSI’s programs. TRaC results as well as routine program monitoring data and project mapping shed light on the effectiveness of PSI’s interventions and activities.

Interviews

In-depth interviews with PSI management and staff, government officials, project partners and beneficiaries were a major source of information for the assessment.

Site visits

The assessment team conducted site visits (see Annex 2 for a list of organizations visited) to locations where PSI implements interventions such as drop-in center activities, peer education, community outreach, VCT, STI, TB treatment and social marketing. Locations for site visits were chosen in consultation with RMDA and PSI. The team also met with government, UN and other INGO partners as well as project staff and beneficiaries.

1.3 Limitations of the assessment

Given the breadth of evaluation questions and themes, beneficiary groups and the geographic coverage in each country, there were limits to the depth of inquiry the two teams could complete in the time available. The size and complexity of PSI's interventions in Burma, China, Lao and Thailand, and the brevity of the site visit period somewhat constrained the depth of information-gathering. In-depth discussions with beneficiaries were limited by time considerations.

2. Key overarching findings

This section synthesizes key overarching findings of this end of project review with a particular emphasis on Burma, China and Lao where the PSI regional project currently has USAID-supported activities. The first set of key findings are grouped under the four objectives PSI was tasked to achieve in their funding proposal to USAID/RDMA over the three years of this agreement extension, FY08-FY10. These key findings are outlined in sections 2.1.1 through 2.1.4. Other key findings of the review are grouped under a range of additional thematic areas in sections 2.2.1 through 2.2.4. Data to support the findings are contained in each of the chapters outlining the work of PSI in the four countries and in Annex 6: PSI results by PEPFAR core indicators and project objectives.

2.1 PSI Agreement objectives

2.1.1 Increase access to prevention interventions for MARPs

All of the MARPs targeted by PSI are hard to reach because of social marginalization and all have relatively high rates of HIV, although this varies by MARP and geographic location. PSI's programs have resulted in significantly increased access to prevention interventions by MARPs. Depth of penetration in accessing MARPs has been high. However, the extent to which PSI's prevention programs have been able to access MARPs also varies by country and by population. Some MARP populations are more difficult to reach than others. For example, in China IDU are particularly difficult to reach as they are well practiced in hiding from law enforcement officials. Growth in access to prevention interventions has been highest in Burma which has the largest scale PSI prevention program of the four countries due to a higher level of USAID funding and a higher level of leveraging of other donor funds. In Burma, coverage of FSW is higher compared to MSM as a larger number of FSW can be reached at the places where they meet clients, whereas MSM are generally more hidden.

Among each of the MARPs being targeted there are sub-populations that are more difficult to access than others (e.g. low-fee sex workers in China, hidden MSM, IDU hiding from law enforcement officials). This highlights the importance of programs examining who they reach and how they can increase coverage to the most at risk and hard to reach.

In Burma and Lao, PSI conducts large scale national social marketing of condoms and water based lubricants through extensive networks of private sector traditional and non-traditional outlets. In Burma, PSI has around 80% of the national condom market and in Lao 58% of the national market. Since 2007, sales and free distribution of condoms and lubricant to MARPs, their partners and the general population have continued to grow significantly. PSI's social marketing activities have significantly grown the size of the condom market and established condom buying habits among MARPs and others.

In some countries there has been overlap between the work of PSI and other USAID CAs working with the same MARP. Usually this has been adequately dealt with by one CA being responsible for one geographic area or segment of the MARP population, with the other CA being responsible for another area or segment. There has been some duplication, but this has been minimal.

Beyond measuring increased access to prevention interventions, PSI routinely tracks behavioral outcomes among the populations they serve. Periodic behavioral surveys conducted by PSI in each country found evidence of positive behavior change in the most at risk populations targeted. These outcomes include higher levels of condom use and consistent condom use among MSM and FSW and in China decreased sharing of needles and syringes among IDU. PSI behavioral data for most MARPs indicates that statistically significant levels of behavior change are achieved when MARPs are exposed to more elements of the comprehensive prevention package. This 'dosage' effect confirms that the comprehensive prevention package approach is both appropriate and needed.

As is common throughout the region, PSI's behavioral data demonstrates that consistent condom use by MARPs is higher with casual and commercial partners than for regular partners. PSI has recognized the need to particularly focus on increasing consistent condom use with regular partners.

Increased safe behavior by MARPs may contribute to the program's strategic goal of reducing the spread of HIV and STIs among MARPS. However, there is insufficient data at this point in time to demonstrate whether this higher level impact is being achieved by PSI. Epidemiological modeling indicate that quite high program coverage levels as well as program intensity need to be achieved for changes in behavior to result in a reduction in incidence, particularly in high prevalence settings. This emphasizes the importance of continued scale-up of prevention programs for MARPs.

2.1.2 Increase access to care and support for PLHA

Although PSI's contractual obligations to USAID centered around delivering a prevention program, a key objective has been to increase access to care and support for PLHA. PSI has recognized the importance of providing a continuum of prevention to care, support and treatment services.

PSI's promotion and provision of VCT services has increased access to HIV testing, enabling MARPs to know their HIV status and be referred to care, support and treatment services. However, as is common with MARP prevention programs in the region, the uptake of HIV counseling and testing is quite low, and most MARPs do not know their HIV status.

PSI promotion and provision of STI diagnostic and treatment services for MARPs has increased access to client-friendly STI services. Although MARP utilization of STI services is mostly at higher levels than utilization of VCT, the uptake of STI clinical services has generally been low, especially in view of high STI rates. Low utilization rates of VCT and STI services points to the need to address demand side issues as well as supply side issues. The introduction of rapid testing for VCT significantly increased VCT uptake among MARPs in China and Lao. PSI's social marketing of pre-packaged, branded STI treatment kits through DiCs and the private sector has increased MARP access to appropriate and quality treatment regimens at an affordable price. There is a need to continue to strengthen quality assurance systems for STI clinical services, particularly in Lao.

In Burma, there has been some integration of HIV and TB clinical services in PSI clinics through the provision of TB screening. USAID support for PSI/Burma's TB program has increased access to free TB treatment on a national scale, with a focus on the poor. However, integration of HIV

and TB has been limited as only a minority of TB cases are having HIV tests due to policy settings which limit the places where HIV testing can be performed.

Access by HIV positive MARPs to care, support and treatment services provided by PSI's partner organizations has been limited in some countries, particularly Burma, because of the small number of treatment places available. In high prevalence settings, PSI increased its focus on the care and support needs of PLHA. While there are linkages with care, support and treatment services, the capacity of all programs to ensure a seamless continuum of prevention to care, support and treatment has been insufficient.

2.1.3 Increase access to strategic information

PSI's program is evidence based and data driven. Routine monitoring and evaluation data, including data collecting using unique identifier codes (UIC), have been continuously analyzed and used in refining project design and implementation. Periodic TRaC surveys have allowed for good assessments of intervention outcomes over time with respect to how behaviors, attitudes, knowledge, and beliefs have changed in target populations. These surveys collect information that demonstrates attribution of improvements in health outcomes directly to PSI programs. Behavioral determinants identified from TRaC surveys are used to create HIV Marketing Plans and an audience profile for each target group which are used to guide how prevention interventions are delivered. Prevention messages are informed by this systematic research on the determinants of behavior. Qualitative research has also been conducted to supplement the quantitative oriented TRaC surveys.

In Burma and Lao, PSI regularly conducts Project MAP (Measuring Access and Performance) surveys to track product availability in all project sites. For example, this is used to measure the location of condom availability in proximity to hot spots. PSI also regularly utilizes GIS mapping to geographically depict its program components, which allows for a quick snapshot of geographical program coverage. In China, PSI, together with other CAs, is leading a process for routine behavioral tracking for MSM and FSW programs.

PSI's strong emphasis on strategic information highlights the value the organization places on evidence-based programming; quality assurance methods are built into its data collection systems; good internal capacity has been built; and the results of research are turned into program action. Areas where performance has been mixed are in using strategic information for advocacy on policy change and program issues at the national and sub-national levels; more regular sharing and dissemination of results to external partners; and greater involvement of MARP communities in evidence-based decision making.

2.1.4 Strengthen the enabling environment

PSI's work has contributed to strengthening the enabling environment in a number of ways:

Capacity building: There has been significant capacity building of the private sector in social marketing of condoms and other health products and in social franchising of health services to improve access by the poor. Social franchising of health services in Burma through the Sun Quality Health and Sun Primary Health networks has been accompanied by capacity building and development of quality assurance systems for private medical practices and community health workers. The capacity of MARPs to design and implement prevention programs has increased significantly in all countries. Capacity building of peers has resulted in a self-

confidence that has reduced internalized or self-stigma and facilitated community mobilization. There has been insufficient capacity building of the technical expertise of clinical staff. The capacity of PSI programs in all countries to ensure a seamless continuum of prevention to care, support and treatment needs continued strengthening.

Community mobilization: PSI's approach has been to foster peer led community mobilization approaches in its work with MARPs. With the exception of Thailand, this has been occurring in the context of government antipathy towards civil society. As an INGO, PSI has been able to more readily work with marginalized community groups than would be the case for local organizations. Although programs are largely PSI implemented, they are characterized by community development and community mobilization approaches. In China, PSI has been able to provide sub-grants to nascent CBOs and strengthen their capacity for implementation and working with government community based HIV programs.

Increased access to services: The provision of STI and VCT services by PSI has ensured that MARPs have easy access to non-discriminatory services that are, especially for STIs, clinically appropriate to their needs. Facilitated referrals to care, support and treatment services have increased MARP access by addressing discriminatory health service practices.

Social recognition: the provision of high profile HIV services for MARPs has resulted in the health and broader social needs of MARPs becoming more visible to local and national health officials and other partners. This social recognition helps to combat stigma and discrimination and further MARP visibility in national strategies and Global Fund proposals.

Safe spaces: DiCs for MARPs represent a social recognition of their needs and provide a safe space which helps increase social confidence and reduce self-stigma. Where PSI prevention programs have had a strong focus on the needs of PLHA, particularly in Burma, this has resulted in a more open and supportive environment for PLHA, which helps to reduce stigma faced by PLHA from their MARP peers.

2.2 Other key findings

2.2.1 Innovation

Innovation has been a strong feature of PSI's programming in all countries. With variation between countries, incentives are used in order to reach program goals. For example, payments are made to MSM peer educators in Lao based on the number of VCT referrals, and to the poorest TB patients in Burma to support transportation costs, with the aim of achieving improved treatment adherence. Innovation has also been used in prevention program design including promotion of the female condom to MSM, use of text messaging to mobile phones to promote VCT, use of peer progression promotion structures for prevention program staff, and use of GIS technology for measuring program coverage in relation to hot-spots.

Innovation has also been a strong feature of PSI's approach to strategic information. This includes the development of client unique identifier codes to facilitate measurement of the number of individuals reached and periodic surveys to track behaviors and the determinants of behavior which are then used to refine interventions and BCC messaging.

Innovative use of social franchising has also been a strong feature of PSI's work. This has included social franchising of a range of health products through traditional and non-traditional

outlets and the development of private medical and primary health social franchising networks in Burma. PSI's social franchising work has resulted in a significant private sector involvement in HIV and other public health work which has considerable potential for sustainability.

2.2.2 Leverage of additional funding and a broader public health focus

PSI has been very successful in leveraging other donor funds for HIV and other public health work. This means that PSI has become less reliant on USAID for funding. This provides a more stable financial base for ongoing operations. Leverage of funds has allowed an expansion of USAID-developed models, resulting in greater access by MARPs to prevention interventions and care, support and treatment. PSI has, to varying degrees in the different countries, been able to build up a portfolio of other public health work. This has allowed for a more integrated approach such as with HIV/TB work. Leverage of other donor funding has enabled PSI to apply its strengths in prevention programming, research, social marketing and social franchising to a broader portfolio of public health work.

2.2.3 Relationship of PSI's work to the Global Health Initiative

The US Government has announced a new Global Health Initiative (GHI), a six year \$63 billion investment that commenced in FY2009, that will provide a common vision for integrated global health programming with an emphasis on health systems strengthening. PSI's work relates to a number of the GHI goals and principles. In the area of strengthening health systems, the capacity of civil society to be active players in the health system has increased significantly and the capacity of the private sector has been increased through social marketing and social franchising approaches. In some countries this capacity building has occurred in the context of fragile health systems, where alternative service delivery mechanisms such as civil society and the private sector have been needed. Public health systems have acknowledged the benefits of this greater involvement by civil society and the private sector.

Other examples of where GHI approaches are evident in PSI's work are:

- An integrated approach to public health: PSI's broader public health work and integration of HIV with reproductive health and family planning and HIV/TB work.
- Outcomes focused: PSI's strong focus on using strategic information to guide programs to achieve outcomes, and the ongoing monitoring of results.
- Leverage: broadening of PSI's funding base beyond USG.

2.2.4 Replication and sustainability

PSI's large scale social marketing of condoms and lubricant has significantly grown the size of the market by developing a demand for these products. This has been accompanied with the development of buying habits for condoms so access to prevention is not solely reliant on free distribution. A possible concern in terms of sustainability is PSI's dominance of the condom market in Burma and Lao. However, PSI recognizes the need to encourage new private sector entrants into the condom market, (which is occurring in Lao), to ensure long term sustainability, whilst ensuring that affordable condoms are available to the poor and most vulnerable.

Public health officials in the four countries are increasingly seeing the value of community led approaches to HIV prevention. However, the broader political environments in three of the four countries are not encouraging for the development of civil society. Considerable work remains to be done in documenting and advocating for this approach. The capacity building of peers has developed knowledge and skills in prevention programming, although there has been a lesser

emphasis on strengthening organizational development given most peer led programs are operating under the auspice of PSI.

Although there has been significant capacity building of local project staff by PSI in strategic information, there has not been a parallel process of developing the capacity of other partners and governments.

PSI's social franchising of health services has good sustainability potential as it has been accompanied by ongoing capacity building of pharmacies, medical practitioners and community health workers.

Replication of PSI's programming has been occurring in a number of ways. As additional funds are mobilized from other donors, this has allowed PSI's existing programs to be replicated in new sites. The elements of USAID's Comprehensive Prevention Package model, being implemented by PSI, has also had a significant influence on the prevention programming of other donors and in the programming approach reflected in Global Fund proposals. PSI has also been active in promoting replication in national and regional forums. More broadly, the HIV and AIDS National Strategic Plans of all four countries now prioritize MARPs and the prevention approaches in these strategies have been strongly influenced by the CPP. This type of replication significantly strengthens sustainability.

3. Burma

3.1 HIV prevalence in Burma

Adult HIV prevalence in Burma in 2009 was estimated to be 0.6%. Sentinel surveillance among pregnant women (32 sites) in 2008 found an HIV prevalence rate of 1.3%. The epidemic is primarily concentrated in MARPs: MSM 29% (2 sites); FSW 18% (6 sites); IDU 38% (6 sites). HIV prevalence among male STI patients (a proxy for clients of sex workers) was 5% (33 sites). HIV prevalence among new TB patients was 11% (10 sites). The 2008 sentinel surveillance survey found prevalence of syphilis was highest among MSM (14%), followed by FSW (6%), new TB patients (5%), and male STI patients (4%).¹

3.2 Overview of PSI/Burma program

PSI/Burma works in six public health areas: HIV/STIs, TB, malaria, reproductive health, diarrheal diseases and pneumonia. USAID/RDMA funding is supporting PSI's work in HIV and TB. For FY 10 USAID funding makes up 31% of PSI's HIV budget and 47% of PSI's TB budget. USAID funding supports the Targeted Outreach Program (TOP) for MSM and FSW services and STI technical assistance and quality assurance for the Sun Quality Health network doctors. Other donors currently supporting PSI's public health programs include United Nations (UN) agencies, the Three Diseases Fund, DANIDA, and the Bill and Melinda Gates Foundation. From 2011, PSI will receive Global Fund Round 9 funds.

The implementation mechanisms used by PSI/Burma to implement its public health programs are:

- The Targeted Outreach Program for MSM and FSW
- Two QC VCT centers in Rangoon and Mandalay for the general population, with a focus on clients of FSW. These centers also conduct sputum testing for TB
- DOTS TB program implemented through the Sun Quality Health and Sun Primary Health networks
- Sun Quality Health (SQH) network, which is a branded franchise network of 1006 private doctors throughout Burma working in all six of PSI public health areas, targeting low income people, with extensive technical support from PSI
- Sun Primary Health, which is a network of 776 community health workers in 33 rural townships delivering health communication messages, basic services, health products and making referrals
- Malaria prevention, diagnosis and treatment program
- Mass media and targeted communications across the six public health areas

3.3 Prevention

3.3.1 Outline of the Burma prevention program

PSI's HIV prevention work for MSM and FSW is provided by TOP, which was established in 2004. The core elements of the program are BCC interventions through peer outreach and DiC activities, condom social marketing, VCT and STI clinical services in DiCs, including social marketing of branded STI treatment kits, and support for PLHA, plus referral to external HIV care and treatment services. In Rangoon and Mandalay, PSI also operates QC VCT centers which are

¹ WHO and National AIDS Program, Report of the HIV Sentinel Sero-Surveillance Survey 2008. 2009.

targeted to the general population, with an emphasis on clients of sex workers. The QC centers also conduct sputum tests for TB. The QC centers are not funded by USAID.

3.3.2 Key achievements

Increased access to prevention interventions for MARPs

TOP's geographic reach

The core elements of the TOP model described in 3.3.1 have been progressively scaled-up since 2004 and these interventions are now provided in 15 townships in Burma. In 2010, TOP will expand to an additional 5 townships, and in 2011 to a further 9 townships, giving the program coverage in 29 locations. Geographic scale-up has been prioritized, by firstly opening programs in larger cities and then expanding to smaller cities/townships. PSI estimates that operations in 29 townships will give it potential reach to 85% of MSM and FSW in Burma. At this level of geographic scale, this would be largest single HIV prevention program for MSM and FSW in Asia. (See Annex 3 for a map of the current locations of the TOP program.)

TOP activity data

The following section provides an outline of TOP activity data which demonstrates significantly increased access to prevention interventions. More detailed data is contained in tables in Annex 4.

TOP outreach activity levels: MSM ²

Outreach is the most important element of TOP as it has the largest reach of all project components. A client unique identification code (UIC) is not used for outreach contacts, but a record of new individual outreach contacts is maintained. (A UIC is used for DiC visits.). Key data for MSM outreach activities are:

- New outreach contacts with individual MSM from 2007–2009 totaled 132,378 which made up 36% of total MSM outreach contacts.
- Total outreach contacts with MSM (not individuals) increased by 47% between 2007–2009 and totaled 372,467 contacts for the three years.
- A total of 147,435 outreach contacts were made with MSM in 2009, which is an average 189 contacts per week, per TOP site. (See Table 6 in Annex 4 for more details.)

TOP outreach activity levels: FSW

Key data for FSW outreach activities are:

- New outreach contacts with individual FSW from 2007–2009 totaled 97,188, which made up 31% of total FSW outreach contacts.
- Total outreach contacts with FSW (not individuals) increased by 46% between 2007–2009 and totaled 317,070 contacts for the three years.
- A total of 130,306 outreach contacts were made with FSW in 2009, which is an average 167 contacts per week, per TOP site. (See Table 7 in Annex 4 for more details.)

TOP DiC activity levels: MSM

From 2004–2009 a total of 38,083 individual MSM visited a DiC on at least one occasion. In 2009, a total of 19,621 individual MSM visited a DiC on an average of 5 occasions. This means that 18,642

² This section provides activity data for the calendar years 2007–2009. USAID funding of PSI's activities under the existing contract extension commenced in October 2007. Accordingly, the 2007 data can primarily be regarded as baseline data for this contract.

MSM who visited a DiC at least once between 2004–2008 did not return in 2009, a non–return rate of 49%. It is likely that a number of these MSM were contacted through outreach activities, although there is no data to indicate the extent to which this was the case. Other key data relating to DiC utilization are:

- Over the period 2007–2009 there were a total of 215,289 visits by MSM to DiCs (not individuals).
- Total DiC visits by individual MSM increased by 92% between 2007–2009.
- The total of 98,137 DiC visits by MSM in 2009, (not individuals), approximates an average of 27.3 visits per day, per DiC, across the 15 sites.³ (See Table 8 in Annex 4 for more details.)

TOP DiC activity levels: FSW

From 2004–2009 a total of 30,721 individual FSW visited a DiC on at least one occasion. In 2009, a total of 15,936 individual FSW visited a DiC on an average of 5.1 occasions. This means that 14,785 FSW who visited a DiC at least once between 2004–2008 did not return in 2009, a non–return rate of 48%. It is likely that a number of these FSW were contacted through outreach activities, although there is no data to indicate the extent to which this was the case. Other key data relating to DiC utilization are:

- Over the period 2007–2009 there were a total of 178,787 visits by FSW to DiCs (not individuals).
- Total DiC visits by individual FSW increased by 87% between 2007–2009.
- The total of 81,414 DiC visits by FSW (not individuals) in 2009 approximates an average of 22.6 visits per day, per DiC, across the 15 sites. (See Table 9 in Annex 4 for more details.)

TOP outreach and DiC coverage

The large increases in outreach contacts and DiC visits by MSM and FSW from 2007–2009 represent a significant achievement in increasing access to prevention interventions. This is one of the four objectives or intermediate results of USAID’s agreement with PSI. The increases in both outreach contacts and DiC visits is driven by expansion of TOP to new sites and increased coverage in existing sites. PSI regards outreach as the ‘backbone’ of the TOP program as it is able to reach more MSM and FSW, compared to DiC visits.

Trends in outreach contacts and DiC visits from year to year have generally shown significant increases, however, the extent of increase for some years has been effected by external factors such as Cyclone Nargis, political unrest and the temporary government closure of the Mandalay DiC.

Because unique identifier codes are only used for DiC visits it is not possible to calculate the total number of individual MSM and FSW reached by TOP. However, incomplete coverage estimates can be determined for 2007–2009 using the following data:

- The number of new outreach contacts (recognizing there may be some double–counting); and
- Deriving a percentage of MSM who came to DiCs without any previous outreach contact with TOP. PSI’s internal monitoring system indicates that 90% of MSM and FSW coming to DiCs say they learnt about the DiC from peer outreach workers and the remaining 10% have had no previous contact with the program. Accordingly, 10% of new individual DiC members can be regarded as new contacts.

³ Calculated on the basis of DiCs being open 240 days a year. Attendance at DiC varies significantly by locality and the average would be depressed because 3 new DiCs would not have been open 240 days.

Using this approach, from 2007–2009 PSI reached a minimum of 134,584 individual MSM. The National Strategic Plan for HIV and AIDS (NSP) estimates 240,000 sexually active MSM, based on an assumption that 2% of males aged 15–49 years have sex with other males in the previous 12 months. PSI regards this estimate as conservative. Coverage of 134,584 individual MSM for 2007–2009 represents a national coverage rate of 56%. By regional standards, this is a high coverage rate.

Using the same approach, from 2007–2009 PSI reached a minimum of 99,444 individual FSW. The NSP estimates there are 60,000 FSW in the country at any given time. This too is seen as a conservative estimate. The population size estimate for FSW may be a significant underestimate as each year there are many new sex workers and many who exit this type of work. Using the NSP estimate, PSI reached 165% of individual FSW between 2007–2009.

TOP is clearly reaching a higher proportion of the estimated number of FSW compared to MSM. This may be because FSW are less hidden than MSM, as many work in entertainment establishments where PSI has good access.

The Myanmar NSP Progress Report for 2008 estimated that PSI reached 78% of all MSM reached by HIV programs in the country that year. PSI's share of total national coverage for FSW in 2008 was 52%.

STI clinical services: MSM

Between 2007 and 2009, the number of STI consultations and/or occasions of treatment for MSM at TOP DiC clinics increased from 3,972 to 8,749, or by 120%. In 2009, only 45% of individual MSM who attended a DiC also had an STI consultation and/or treatment. In 2007, 39% of DiC attendees had an STI consultation or treatment. A bigger increase might have been expected given the increased availability of STI clinics at DiCs over this period. (See Table 10 in Annex 4 for more details.)

STI clinical services: FSW

Between 2007 and 2009, the number of STI consultations and/or occasions of treatment for FSW at TOP DiC clinics increased from 4,948 to 9,153, or by 85%. In 2009, 57% of individual FSW who attended a DiC also had an STI consultation and/or treatment. The percentage of FSW attending STI clinics did not vary significantly from earlier years. Growth in the percentage of FSW utilizing clinics might have been expected given the increased availability of STI clinics at DiCs over this period. Compared to MSM, the STI health seeking behavior of FSW is better. (See Table 11 in Annex 4 for more details.)

VCT services: MSM

The number of MSM having VCT at TOP DiCs increased from 1,520 in 2007 to 2,514 in 2009, or by 65%. The number of MSM who tested positive at TOP DiCs ranged by year from 11–17%. The percentage of individual MSM attending DiCs who also had VCT was low, ranging from 15% in 2007 to 13% in 2009. (See Table 12 in Annex 4 for more details.)

VCT services: FSW

The number of FSW having VCT at TOP DiCs increased from 2,022 in 2007 to 2,664 in 2009, or by 32%. The number of FSW who tested positive at TOP DiCs ranged by year from 17–19%. The

percentage of individual FSW attending DiCs who also had VCT was low, ranging from 24% in 2007 to 17% in 2009. (See Table 13 in Annex 4 for more details.)

TOP STI and VCT coverage

VCT services in TOP DiCs have only been available since December 2009, with the exceptions of Rangoon and Mandalay where these services commenced in 2005. STI services at DiCs have been rolled out progressively to DiCs, mainly in 2008 and 2009. The more extensive provision of STI services over a longer period of time may explain the higher growth rate for MSM attending for STI services compared to VCT. The recent expansion of both VCT and STI services is likely to result in an increase in service utilization.

2009 STI and VCT coverage rates by PSI for MSM and FSW in relation to the estimated total population sizes for Burma were low, but higher for FSW compared to MSM:

- MSM use of TOP STI services = 3.6% coverage
- FSW use of TOP STI services = 15% coverage
- MSM use of TOP VCT services = 1% coverage
- FSW use of TOP VCT service = 4.4% coverage

It is possible that MSM and FSW who use PSI DiCs are having HIV tests in VCT services provided by other service providers. There is, however, no data on this and given most other VCT clinics are government clinics, the number of MSM testing at other centers may be small. However, it is important to note that once a MARP is HIV positive and knows their status, they no longer will need HIV testing. Given that HIV prevalence in the country is mature and particularly high in these populations, there may be a significant proportion of HIV positive MARPs who already know their status. However, given the low rates of HIV testing among MSM and FSW as indicated by the PSI data, this is unlikely to be the case.

Technical assistance and quality assurance for STI and VCT services

PSI has clinical guidelines and standard operating procedures in place for its STI and VCT clinical services. FHI's regional Technical Advisor for Sexual and Reproductive Health provided a four day training course on STI management, with a particular focus on MSM and FSW, to PSI and Alliance medical staff in 2009 and has done similar trainings in previous years.

PSI/Burma employs 78 medical practitioners in its headquarters who are responsible for providing technical assistance and quality assurance across PSI's six public health/disease areas, including STIs, to the Sun Quality Health network doctors, and to doctors working in the TOP clinics. Younger PSI doctors conduct monthly visits to all Sun Quality doctors and TOP clinics, monitoring the work of doctors against PSI's protocols. If problems with clinical practice are found, a more senior doctor from the 'champions' PSI has for each public health area is called to provide more specialized guidance. For STIs, these champion doctors have been sent to Thailand for specialized short course training. Sun Quality and TOP doctors participate in quarterly review meetings for clinical and practice updates. Refresher training is also conducted. Mystery clients were used to monitor quality. This is being replaced with mystery observers. In smaller townships, Sun Quality doctors are contracted to work in TOP clinics. Sun Quality doctors are usually the more senior doctors in town.

TOP condom and lubricant sales and distribution to MSM and FSW

From 2007–2009 sales of female condoms to MSM by TOP increased by 546% from a low base. In 2009, female condom sales to MSM were 15% greater than sales to FSW. Sales of female condoms

to female sex workers declined by 25% between 2007–2009 but were still high compared to other countries in the region.⁴ See Table 1, below.

Table 1 : Female condom sales by TOP to MSM and FSW: 2007–2009

Year	Female condoms sold to MSM	% increase on previous year	Female condoms sold to FSW	% decrease on previous year
2007	17,681	–	133,040	–
2008	39,727	125	127,870	– 4
2009	114,278	188	99,751	– 22
Total	171,686		360,661	

Source: PSI/Burma

Sales of male condoms and lubricant to MSM and FSW by TOP is not disaggregated. Between 2007–2009 sales of male condoms to MSM and FSW increased by 101%. The growth in sales from 2008 to 2009 was significantly less compared to the previous year. The increasing popularity of female condoms among MSM in 2009 may have limited the growth of male condoms sales to MSM. PSI markets small tubes of water based lubricant in addition to smaller single–use sachets. From 2007–2009 sales of lubricant tubes increased by 61% and sales of sachets increased by 6,061% from a very low base. See Table 2, below.

Table 2: Male condom sales by TOP to MSM and FSW: 2007–2009

Year	Male condom sales to MSM and FSW	% increase on previous year	Lubricant tube sales to MSM and FSW*	% increase on previous year	Lubricant sachet sales to MSM and FSW*	% increase on previous year
2007	235,485	–	27,868	–	1,240	–
2008	410,620	74	20,878	– 25	4,800	287
2009	472,840	15	44,729	114	76,400	1,491
Total	1,118,945		93,475		82,440	

* Gel tubes contain 20 cc of water based lubricant. Gel sachets contain 5 cc of water based lubricant. Source: PSI/Burma

In 2008 TOP reached a minimum of 54,067 individual MSM and 40,935 FSW.⁵ In 2009, TOP sold/distributed an average of:

- 2.1 female condoms to each MSM reached
- 2.4 female condoms to each FSW reached
- 5 male condoms to each MSM/FSW reached (disaggregated data not available)

In addition, 1.063 million Aphaw Gel condoms and sachets of lubricant were sold through PSI’s broader condom social marketing program (see below). Assuming the market for jointly packaged condoms and lubricant is MSM and FSW, this equates to an average of 11 sales per MSM/FSW reached by TOP. Alternatively, using combined population estimate data for MSM

⁴ PSI markets female condoms under two brands: Feel for Men and Feel for Women. In 2008 stock–outs of Feel for Men resulted in Feel for Women condoms being sold to MSM. In 2009 there were no stock–outs of Feel for Men which led to a reduction in sales for Feel for Women sales in 2009 compared to 2008.

⁵ These figures are made up of all MSM and FSW reached by outreach for the first time, plus 10% of new DiC members and DiC members who registered in previous years and used in the DiC in 2009. The numbers of MSM and FSW reached are underestimates as repeat outreach contacts with MSM reached in previous years are not included (no data available). Accordingly the average sales of condoms per MSM/FSW reached are an overestimate.

and FSW (i.e. 300,000 people) it equates to 3.5 condoms sales per MSM/FSW. However, as other brands of male condoms are also purchased by MSM and FSW, these are underestimates of condom sales.

PSI's broader condom social marketing program

In addition to the sales and distribution of condoms and lubricant by TOP, PSI's broader national condom social marketing (CSM) program, through 3,772 traditional and 4,380 non-traditional outlets, sells a range of male condom brands to a broad range of population groups, including MSM and FSW. It is, however, not possible to collect data on sales to different populations groups. From 2007–2009, sales of male condoms increased by 32% to a total of 26.6 million condoms (Table 3). PSI estimates that it has approximately 80% of Burma's condom market. Four percent of total male condom sales in 2009 were the 'Aphaw Gel' brand which jointly packages condoms and water-based lubricant. This brand would usually be purchased by MSM and FSW. As tubes of lubricant are also marketed by PSI, MSM and FSW may purchase other brands of condoms that are not packaged with lubricant and use the tubes for lubricant. From 2007–2009, sales of lubricant tubes increased by 113% and sales of lubricant sachets (jointly packaged with condoms) increased by 33%. Approximately 8% of the total 26.6 million condom 'sales' in 2009 were for promotion and free distribution. Total income from sales of condoms in 2009 was \$0.387m. One-third of this income was attributable to condoms purchased with USAID funds. Income is generally used for purchasing further commodities, packaging and similar purposes.

Table 3: Male condom sales by PSI's broader condom social marketing (non-TOP): 2007–2009

Year	Male condom sales	% increase on previous year	Lubricant tube sales	% increase on previous year	Lubricant sachet sales	% increase on previous year
2007	20,223,947	–	24,461	–	801,597	–
2008	23,350,288	15	22,921	– 6	1,123,263	40
2009	26,616,218	14	52,143	127	1,063,600	– 5
Total	70,190,453		99,525		2,988,460	

Source: PSI/Burma

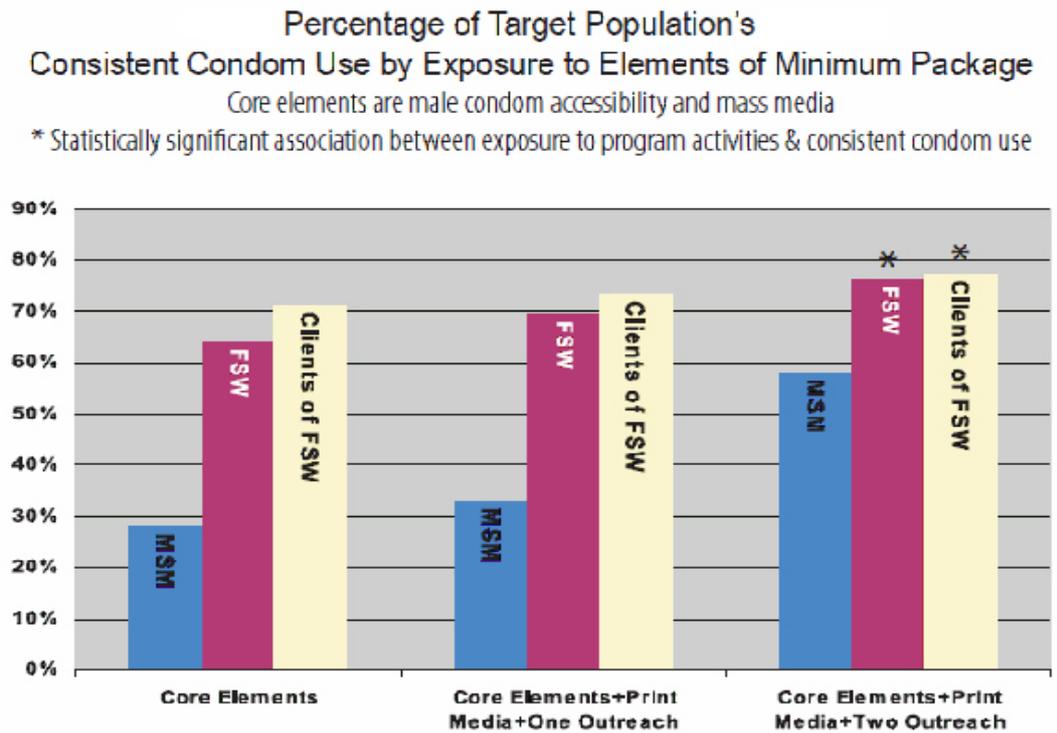
Behavior change

Behavioral data from TRaC surveys with female sex workers and their clients mostly showed improved safer sexual practices. For female sex workers, consistent condom use with commercial partners in the past week improved from 67% in 2003 to 87% in 2008. Over the same period, national HIV surveillance showed a reduction in HIV prevalence among FSW from 31% to 18%. Consistent condom use with regular partners in the past month was first measured in 2008 and was 68%. For clients of sex workers consistent condom use with sex workers in the past month increased from 58% in 2003 to 87% in 2008. However, consistent condom use by clients of female sex workers with regular partners declined from 23% in 2003 to 13% in 2008.

For MSM the baseline TRaC survey was conducted in 2008, with a further survey to be conducted in 2010. The 2008 survey found that 62% of MSM consistently used condoms with casual partners in the past week and that 51% consistently used condoms with regular partners in the past month.

PSI's TRaC surveys in Burma have found that consistent condom use by MSM, FSW and clients of FSW increases when they are exposed to additional elements of the comprehensive package of services, (formerly called the minimum package of services) and multiple outreach contacts (see Figure 1 below).

Figure 1: Percentage of target population's consistent condom use by exposure, 2008



Source: PSI/Burma

Increased access to care and support for PLHA

Since 2007, TOP has provided increased care and support to MSM and FSW PLHA through its DiCs. Specific initiatives have been:

- TOP has trained volunteer peer 'buddies' to provide care and support to PLHA.
- The FHI self care booklet has been translated and distributed to PLHA.
- All DiCs are now open on Saturdays for the exclusive use of PLHA. This is called the Saturday Club and includes peer psycho-social support and small scale income generating projects.
- A national network of positive MSM and FSW has been established under the auspice of TOP.

All MSM and FSW who test positive for HIV are referred to external care and treatment services. Access to HIV care and treatment services in Burma varies significantly by geographic area, but is generally limited. In particular, access to ART is very limited, with a significant gap between need and supply. Access to ART will improve slowly, starting in 2011 with the Global Fund round 9 grant, but there will still be a large gap between ART need and the available treatment places.

In November 2008, PSI/Burma launched an ART pilot project in Rangoon at the QC Center, TOP DiC, and eight SQH clinics for 50 HIV positive clients who met clinical eligibility criteria. Counselors at the QC Centers provide adherence counseling to all ART clients because SQH providers have less time for counseling. This is an innovative new pilot and should be watched carefully as this type of service could be incorporated into PSI/Burma's existing programs. This would provide a direct link in the continuum of prevention to care, support and treatment. And given that the ART coverage is still low, reaching only one fifth of the people in need, additional

and alternative investments in ART provision remains an urgent need⁶. If the pilot were to be expanded and incorporated into PSI's existing program it would have significant financial and human resource implications for the clinics at DiCs. This would require either additional resources or some diversion of prevention program funding.

Strengthening the enabling environment

Although TOP has no identifiable separate program component for strengthening the enabling environment, its activities have contributed to this indirectly in a number of ways:

- The scale-up of services to 15 sites has resulted in the needs and challenges of MSM and FSW becoming more visible to public health officials and service providers at both the township level and to the National AIDS Program. MSM were recognized as a MARP for the first time in the National Strategic Plan, 2006–2010.
- DiCs for MSM and FSW provide both social recognition and safe spaces and this has helped to increase social confidence and reduce self-stigma.
- DiCs have provided safe spaces for being open about HIV status. This has reduced stigma faced by PLHA from MSM and FSW peers.
- The provision of on-site VCT and STI services has provided access to non-discriminatory, MARP focused services.
- Capacity building of peers has provided a sense of self-confidence which has reduced internalized self-stigma and facilitated community mobilization.
- Facilitated referrals to care, support and treatment services have increased MSM and FSW access to care, treatment and support by overcoming discriminatory health service practices.

3.3.3 Strengths and facilitating factors

Significantly increased access to prevention interventions by MSM and FSW has been achieved by TOP having a strong orientation towards scaling-up. This has resulted in a 'boutique' type project reaching significant scale. Scale-up has had a dual focus of expanding to new townships and reaching an increasing number of MSM and FSW in existing sites.

While TOP is a PSI program, a community mobilization approach has been taken. All aspects of program development and implementation have been conducted by peer MSM and FSW. Strengthening the capacity of peers has been a core feature of TOP. TOP has held three annual National Network meetings, one for MSM and one for FSW, which brings program staff and peers together for review and capacity building. Achieving a community mobilization approach in the context of Burma, where civil society organization is not permitted, is a very significant achievement. PSI, as a large INGO, has been able to auspice and provide the protection for this to occur on a national scale.

While the TOP has been implementing the core elements of USAID/RDMA's Comprehensive Prevention Package, testing of innovation has been a strong feature of program development:

Separate DiCs for MSM and FSW in the one building in each of the 15 sites

In smaller DiCs the one clinic provides VCT and STI services to MSM and FSW, resulting in cost savings. Combined DiCs also result in cost savings in rental, management and other overheads. This approach also allows for cross-fertilization between program staff working with MSM and FSW and some combined program activities for MSM and FSW such as the Saturday Clubs for

⁶ National Strategic Plan for HIV and AIDS in Myanmar, National AIDS Program; Progress Report 2008

PLHA. Combining DiCs for multiple MARPs is not commonly seen in other countries. In Burma there appears to be a high degree of acceptance of this approach by MSM and FSW.

Broad targeting of all MSM and FSW

While a segmented approach to HIV prevention interventions is often used in other countries, with different community-based organizations (CBOs) targeting different sub-populations of MSM and FSW, TOP targets all MSM and FSW. Measuring the extent to which TOP reaches a broad diversity of MSM and FSW is hard to gauge in the absence of data. However, DiCs appear to be attracting both feminized and non-feminized MSM, but more feminized MSM compared to non-feminized MSM, and also different types of FSW (e.g. entertainment establishments and street based). Outreach provides a basis for reaching a broader cross-section of MSM and FSW. Broad targeting, which results in different groups sharing the one DiC space, appears to be working well. This approach also results in cost savings.

Condom and lubricant social marketing

Program monitoring data indicate that around 80% of male condoms marketed through TOP are sold at subsidized prices to MSM and FSW, with only 20% being provided for free or used for promotional purposes. Female condoms are generally only sold due to a higher unit cost, although they are subsidized. The emphasis on selling condoms encourages buying habits among MSM and FSW for the purpose of sustainability. Comparable HIV prevention programs for MSM and FSW in Asia generally place a greater emphasis on free distribution, and many have only limited supplies for free distribution.

PSI/Burma increased condom coverage in traditional outlets by sub-contracting condom distribution to a private sector company with a well established national distribution network. This has allowed PSI/Burma sales and outreach teams to concentrate on condom distribution to non-traditional outlets.

Promotion of the female condom

An innovative aspect of PSI's programming is promotion of female condoms for male-to-male sex. This is accompanied by small group education sessions for MSM on how to safely use the female condom. Sales figures for female condoms to MSM show a high degree of acceptability of this method of protection. However the active promotion of female condoms to MSM increases program costs, even with a social marketing approach. This is because female condoms are considerably more expensive than male condoms and they are heavily subsidized. There is also strong promotion of the female condoms to FSW, particularly compared to other countries.

Promotion of lubricant

Another innovation is the development and marketing of branded tubes of water-based lubricant to MSM and FSW, in addition to selling sachets of lubricant, jointly packaged with condoms. In most other countries lubricant is only socially marketed in sachets. Sales figures indicate that these tubes, which are small enough to conveniently carry, are popular with MSM and FSW. Beyond the increase in condom use which occurs when lubricant is available, lubricant use alone is a harm reduction method, as it prevents anal and vaginal tears and fissures which increase HIV transmission.

On-site VCT and STI services

All DiCs now have on-site VCT and STI clinical services for MSM and FSW. This promotes ready access rather than relying on referrals to external services and clients can be confident of stigma-

free services. TOP employs peer VCT counselors who have been trained and accredited by the Ministry of Health. This peer driven approach is intended to increase HIV testing rates by providing counselors who understand MARP lifestyles and needs. PSI is only one of two NGOs in Burma which is allowed to provide VCT. Rapid testing is available in Rangoon and Mandalay.

Integrated approach to TB

TB screening, treatment and referral has been integrated into the work of the TOP clinics, including provision of cotrimoxazole prophylactic therapy for TB/HIV co-infected clients. All TB cases are counseled for HIV testing and all HIV positive cases are screened for TB.

Structured behavior change messages

All new outreach contacts receive a structured 45 minutes behavior change communication session from a peer educator, the content of which is informed by PSI's research on the determinants of behavior. Repeat contacts reinforce different messages and answer peer questions.

Addressing the needs of PLHA

A defining feature of TOP is its work with MSM and FSW PLHA. This stands in contrast to HIV prevention programs in other countries in the region where programs often have an implicit orientation towards HIV negative peers. There is evidence of PLHA in TOP DiCs being open about their HIV status. This may be related to the high HIV prevalence among MSM and FSW (at least in some sites), but also appears to be related to a significant number of peer staff being open about their HIV status and a decision by TOP to facilitate an open and supportive environment for PLHA. A range of programmatic initiatives (e.g. the Saturday Clubs) have also fostered this openness. Additionally, the PSI national warehouse is staffed entirely by PLHA.

All of these innovations have helped develop a richer and more robust model. While there has been some dissemination at regional workshops on some aspects of TOP's innovation, formal documentation and dissemination would help to inform MSM and FSW programs in other countries of the benefits of these innovations.

3.3.4 Challenges and barriers

The following challenge and barriers were identified:

Reach into hard reach populations

Although data on increased access to HIV prevention interventions demonstrates an impressive depth of penetration, PSI recognizes that there is a need to further increase coverage in existing sites by extending its reach, particularly for MSM. As is common with HIV prevention programs for MSM in the region, reach is higher for working class MSM, with lesser coverage for middle class and upper class MSM. PSI has explored different methods of accessing these MSM and they do appear for certain large-scale social events.

Consistent condom use with regular partners

As with other countries in the region, behavioral monitoring has indicated that consistent condom use by MSM and FSW with regular partners is significantly less than for casual partners. Similarly, consistent condom use by the clients of sex workers with their regular partners is less than with sex workers. TOP has identified this as a focus area for its work in 2010.

Condom social marketing

PSI's orientation towards condom social marketing and limited distribution of free condoms and lubricant is not shared by all other INGOs operating in Burma. As these INGOs are also working (on a lesser scale) with MSM and FSW, their free distribution of condoms and lubricant could undermine the buying habits that PSI is attempting to establish. PSI could undertake advocacy work with these partners on the benefits of social marketing.

Lubricant supplies

In previous years there have been supply shortages for the small tubes of lubricant. This product is clearly popular with MSM and FSW and efforts should be made to increase supplies.

STI check-up and VCT utilization rates are low

The recent expansion of STI and VCT clinical services has increased access. This needs to be accompanied by generating demand for these services. Rapid HIV testing cannot be provided in most DiCs due to unreliable electricity supply which means that cold chain cannot be maintained for test kits. In these instances, blood is taken and sent to government laboratories. The main disadvantage is the need to ensure that clients return for their test results.

Opening hours of DiCs

All 15 DiCs are open from 9–5 Monday to Friday. While this time appears suitable for FSW who mainly work at night, opening in the early evening may be suitable for MSM, especially those who are working. This may help broaden reach into more middle class MSM.

STI and VCT quality assurance

It was not possible to assess the adequacy of PSI's STI and VCT quality assurance system. Following his 2009 technical inputs, FHI's regional Technical Advisor for Sexual and Reproductive Health recommended that both PSI and the Alliance strengthen their oversight of clinical service delivery in Burma.

Care, support and treatment

High HIV prevalence rates among MSM and FSW and the low availability of care and treatment services in the country has resulted in PSI placing a greater emphasis on care and support for PLHA. When PLHA are referred to care, support and treatment programs, limited availability of ART in Burma means that the services have been limited to clinical monitoring, care and treatment of opportunistic infections. PSI is looking to strengthen its capacity to support MSM and FSW PLHA. One option would be to establish a care and treatment support function/unit within TOP DiCs to facilitate referrals to care, support and treatment services and to advocate on behalf of PLHA experiencing access problems, to provide psycho-social support, adherence support and possibly case management or joint case management with other services. However, under this model the DiCs would not directly provide clinical services beyond the current range of services.

3.3.5 Replication and sustainability

PSI has been able to successfully leverage significant amounts of non-USAID funding to support its HIV work. Additional funding from other donors has allowed scale-up to new townships and replication of the model on a broader scale. By the end of 2011 TOP will be operating on a national scale. This is also the product of having one implementing organization (i.e. PSI through its TOP program). National level scale up would have been difficult if funding was for range of different NGOs/CBOs.

PSI/Burma estimates that it has 80% of the national condom market. This is a significant achievement which has made quality condoms at an affordable price accessible to the people of Burma. Expansion of condom social marketing has been accompanied by significant capacity building of the private sector and this will be reinforced with the contracting out of PSI's national condom distribution. PSI's dominance of the condom market may have negative implications for long term sustainability. It would be highly desirable if there were more marketers of condoms. While the subsidization of condoms can make it difficult for others to compete with PSI, increasing the prices of PSI condoms could result in a significant reduction in sales to the poor. Addressing this issue is complex. One approach is to keep the price of at least one socially marketed brand low, while modestly increasing the cost of other socially marketed brands. This approach recognizes that there are a range of market segments with different price sensitivities. Also, as condom use and buying habits become more established there may be less overall price sensitivity in the market. As a general principle condom social marketing should be done in such a way that it does not prevent or discourage other entrants to the market, whilst at the same time ensuring that condoms are available at a price where those at risk can afford them. At a minimum PSI is well placed to provide technical assistance to potential private sector marketers of condoms on a range of marketing and logistical issues. PSI is aware of these issues and proactively developing a strategy to encourage a diversity of condom suppliers in the market.

Capacity building has been a strong feature of PSI's program. This has included significant capacity building of the private sector in the context of a fragile public sector health sector. The Sun Quality Network has proved to be an effective way of delivering public health services through general practitioners on a national scale. The extensive capacity building of MSM and FSW by TOP has provided a de-facto CBO style organization with capacity for self management.

Prior to the establishment of TOP in 2004, there were no MSM friendly and clinically appropriate STI services for MSM and FSW in Burma. TOP has concentrated its efforts in developing internal capacity to provide STI clinics in DiCs. Unlike other countries, there has been no capacity building of government STI clinics. The capacity of Sun Quality doctors to provide STI services has been developed although this has not included clinical skills on STIs in MSM. PSI is planning to develop the capacity of Sun Quality doctors to provide MARP appropriate and friendly STI services. This should be accorded a high priority in the interests of sustainability.

3.4 Strategic Information

3.4.1 Outline of key strategic information activities

Strategic information refers to the kind of evidence-based information needed to inform policy and planning decisions. Strategic information on HIV comes from four main sources:

- Surveillance
- Monitoring and evaluation of ongoing programs
- Health information systems
- Research

PSI/Burma's strategic information activities have been in the following four areas:

1. **Project MIS System** monitors program service delivery and allows for reporting on indicators at the output level, including intermediate results.

2. **TRaC Surveys** collect the data used to track evolving trends in logical framework indicators at the purpose, output, and activity levels within the target population. TRaC surveys provide detailed data important to social marketing segmentation, monitoring, and evaluation on a timely basis, enabling fine tuning of project interventions every year during implementation.
3. **Project MAP** service delivery surveys monitor and evaluate the relationship between product and service availability and quality and behavior among target populations.
4. **Qualitative Research** is used for concept development, pre-testing intervention materials, item generation (for TRaC surveys) and, if necessary, exploring questions raised in segmentation. The specific strategy used depends on the topic and can result in the use of key informant studies, focus groups, in depth interviews, or peer ethnographic research.

The Strategic Information Department has a total of 23 employees. The staff are mostly country nationals who conduct the routine M&E and research activities. This sub-section reviews the strategic information activities contained in the PSI/Burma annual workplans for the period 2007-2010. An outline of these activities is Annex 5.

3.4.2 Key achievements

Increased access to strategic information

PSI/Burma programs are evidence based and data driven

Routine program monitoring and evaluation

PSI/Burma continuously analyzes routine program data and using it for quality project design and implementation. Data flow from routine program M&E is logical to ensure a good continuous feedback loop of information to all levels of the program.

Project MIS System and data flow for the TOP Centers

Routine program data are collected through a Project MIS system. During outreach and at the DiC service delivery sites, client participation data are collected through paper-based systems by peer outreach workers and DiC staff. Additionally, clinical service data are also collected through paper-based systems by staff doctors and laboratory technicians. The data are then aggregated and cleaned on a weekly basis and entered into an excel spreadsheet by a person with MIS skills at each Top DiC. These data are reviewed on a weekly basis by TOP's National Director and the TOP Technical Support Unit (TSU). The TOP management staff have weekly meetings where the week's data are reviewed and issues are discussed. If any improvements need to be made after looking at the data, then the TSU works closely with the TOP DiC staff and peer outreach workers to implement changes.

Additionally, the TOP Center routine program data are aggregated on a monthly basis by the MIS specialist and the data are displayed on whiteboards within the DiC for clients and peer staff to see monthly performance. These monthly data reports are also sent to the PSI/Burma HQ office where the Strategic Information and Research Department manages the monthly data from all TOP Centers in a database. The TOP National Director also receives a copy of the aggregated monthly data from all TOP Centers and shares that with DiC staff.

The PSI/Burma MIS Team reviews and cleans aggregated data and does follow-up data quality checks with individual TOP Centers if data do not look correct. There are also checks that have

been employed throughout the system to ensure data quality and program quality. PSI/Burma conducts pre- and post-BCC session tests with the target groups to monitor the quality of BCC sessions. In addition, mystery clients or mystery observers are sent to prevention outreach sessions, DiCs and clinical services to monitor the performance of these activities. Finally, the SI and Research Department also aggregates data on a semi-annual and annual basis for analysis of trends and for reporting purposes to donors on intermediate results from program implementation. PSI/Burma reports results to USAID/RDMA annually.

An innovation that PSI/Burma has employed in their MIS system is the use of a Unique Identifier Codes (UIC) to monitor the extent and depth of program prevention coverage of DiC registrants. The use of an UIC is an anonymous way for program staff to measure individuals reached (rather than just number of contacts). This system reduces double-counting and tracks uptake of DiC services by the client, providing records of service use patterns.

PSI/Burma reported that they periodically send routine M&E program data to the National AIDS Program in the Ministry of Health. However, this is more on an as-requested basis. There has been good coordination and collaboration between PSI and the NAP to try and harmonize the clinical service forms that are used for VCT and STI treatment. A functional national HIV Monitoring and Evaluation Framework and Technical Working Group do not exist.

Research

PSI/ Burma conducted TRaC surveys annually from 2004–2008 for FSW and clients of FSW. For MSM the baseline TRaC survey was conducted in 2008, with a further survey to be conducted in 2010. TRaC surveys have allowed for good assessments of intervention outcomes with respect to how behaviors, attitudes, knowledge, and beliefs have changed over time in these target populations. The TRaC surveys are used to monitor behaviors and determinants of behavior and evaluate behavioral outcomes of the target MARP populations. This information is used for program design and implementation. For example, the behavioral determinants that are identified from surveys are used to develop a HIV Marketing Plan, which is the strategic plan that describes how a prevention intervention project will be delivered. Additionally, these identified behavioral determinants are used to develop an “audience profile” for each target population, which is used during program design and implementation. Behavioral determinants are used to develop key BCC messages and IEC materials. These messages and materials are tested and then packaged for delivery through appropriate channels.

In summary, PSI/Burma’s research work assesses the extent of outcomes from interventions and uses this evidence-base to continually tailor their prevention strategies. TRaC data are regularly disseminated to all PSI/Burma. However, there is limited sharing of TRaC data with PSI’s partners. It was reported that TRaC reports are available on the PSI HQ web site. PSI/Burma also conducts TRaC surveys for their malaria and diarrhea programs.

In 2008, the Research Team changed the sampling strategy and will now do TRaC surveys every other year in the same target MARP populations. Since there is a change in sampling methodology, there will be a break in trends over time from 2004–2008. The 2009 TRaC will now be the baseline (using the new sampling methodology) and subsequently the 2011 TRaC will provide the second data point.

Qualitative research and special studies

In 2009 PSI/Burma conducted a small bio-behavioral study among MSM in the TOP Center in Rangoon⁷. Respondents were selected from DiC visitors. The study sample was made-up of 310 feminine MSM and 340 masculine MSM. HIV prevalence was alarming high in feminine MSM at 41%. Although HIV prevalence among masculine MSM was lower than for feminine MSM (23%), it was nonetheless high. Gonorrhea prevalence was 7% among feminine MSM and 12% among masculine MSM. Syphilis prevalence was 11% among feminine MSM and 4% among masculine MSM. Condom use at last anal sex was low among all respondents (46% for feminine MSM, 42% for masculine MSM). Nearly half of all masculine MSM had female partners, as opposed to only 3 of the feminine MSM. This small study helped the DiC staff understand the behaviors of their client population and the rates of HIV and two STIs. Data were analyzed and used to help strengthen prevention programming for both sub-populations.

In other qualitative research activities, PSI/Burma will be collaborating with WHO to do a client health seeking behavior survey in 2010–2011.

PSI/Burma research and SI technical staff have been invited to participate in new national incidence modeling work that UNAIDS is leading. This work will look at modes of HIV transmission using the Asian Epidemic Model (AEM) to help supplement the weak national data coming from NAP BSS and HSS surveys. Additionally, PSI/Burma will be assisting the NAP Technical Support Group in the next round of population size estimations.

Project MAP

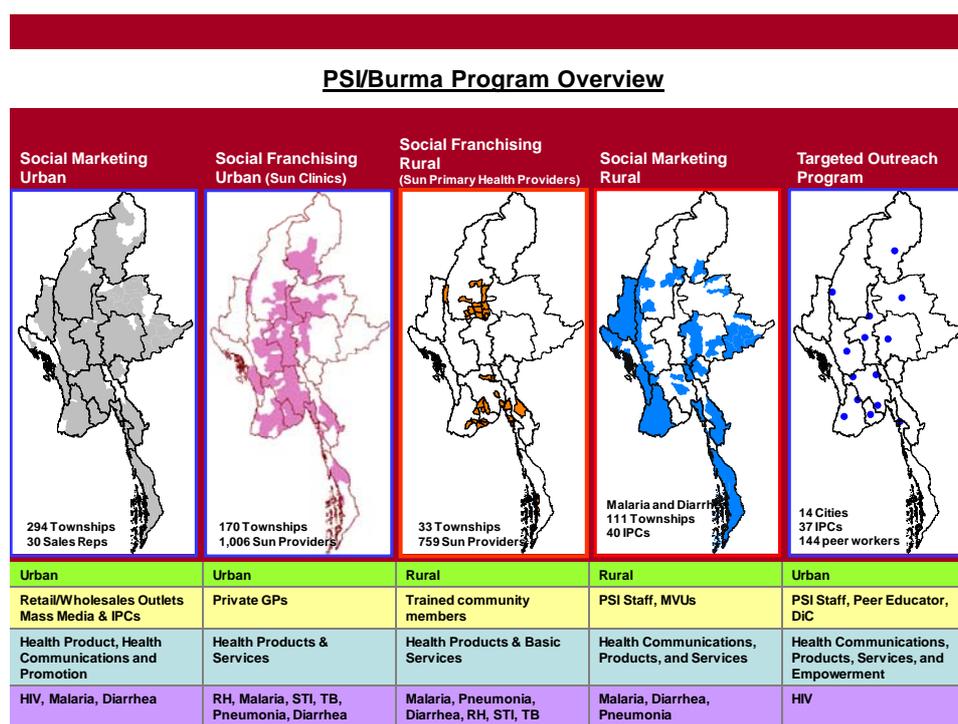
PSI/Burma regularly conducts Project MAP (Measuring Access and Performance) surveys to track the availability of prevention products such as condoms and lubricant in all MSM and FSW project sites. In 2008, a MAP study on male condom availability in places where commercial sex takes place was conducted with geo-references in Mandalay and Rangoon. Locations for commercial sex were grouped together as hot zones if they were situated within 300 meters of each other. Lot quality assurance sampling (LQAS) methodology was used, with random selection of 19 hot zones in each city for outlets selling male condoms. The results of the survey showed that condom coverage in hot zones in Rangoon was 90% for any condoms and 90% for PSI socially marketed Aphaw condoms. In Mandalay coverage was 65% for any condoms and 60% for PSI socially marketed condoms⁸. These data were used by the condom social marketing team to make adjustments in program planning.

PSI/Burma also regularly utilizes GIS mapping to geographically plot its program components. An example of the application of GIS mapping is illustrated in Figure 2, below. This allows for a quick snapshot of geographical program coverage. This strategic information tool is useful for planning program expansion and scale-up, especially when overlaid with epidemiological data. It can also be used to understand overlaps in geographic coverage by other programs. There are many uses for GIS mapping and PSI/Burma has the tools and technical expertise to employ it in its own programming and also provide technical assistance externally.

⁷ Data collected from a presentation titled, "Presentation of MSM Survey" that was given to the Assessment Team by Habib Rahman.

⁸ 2008 PSI/Burma MAP Study

Figure 2 9: Example of GIS mapping in PSI/Burma program



Source: PSI/Burma

3.4.3 Strengths and facilitating factors

Strong staff technical capacity for conducting research and analysis. PSI/Burma has a strong internal capacity for conducting strategic information activities. The PSI/Burma staff are seen by partners as leaders in strategic information and are regularly sought out by government, NAP, and other stakeholders (i.e., UNAIDS, WHO) for technical support at the national and sub-national levels. PSI/Burma is a long-standing member of the national HIV Technical Strategy Group for the Three Diseases Fund and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) CCM.

Turning research into action. PSI/Burma routinely turns both program monitoring data and research into actionable events that are linked directly to improving their programming thus making their programs evidence-based.

Supportive leadership and adequate human resources. PSI/Burma has a large strategic information and research department that is well staffed. There is a special priority that is placed on strategic information and research that comes from the highest levels of the organizational structure. This belief that strategic information is necessary, critical, and useful to implement their programs and demonstrate their performance is to be commended.

Applying private sector approaches/models to international public health. PSI/Burma employs many private sector approaches/models to their international public health work. These business practices as well as some broader conceptual approaches (i.e. social marketing, social franchising,

⁹ Presentation titled “Sample MIS Data” provided by the PSI/Burma staff in the Assessment Team Packet of materials for desk review.

“total market approach”, DALY measurement of performance), impose rigor that allows alternate ways to measure performance of their programs.

3.4.4 Challenges and barriers

Analysis of strategic information is not always tied to advocacy. While strategic information is used for internal program improvement, it is not always turned into external advocacy messages with a goal of policy change at the national and sub-national levels. One example where PSI has successfully lobbied the NAP is the inclusion of MSM in the National Strategy and subsequent focus as a priority group in the successful Global Fund Round 9 proposal.

Dissemination of PSI/Burma strategic information and research needs strengthening.

PSI/Burma does a good job of disseminating results from monitoring and evaluation and research internally; however, there has been limited sharing and dissemination of strategic information externally.

Involvement of community members in evidence-based decision making. Government-community partnerships are nascent in Burma and there is a major challenge in how to best involve community members in these processes at a higher level. PSI has strong community involvement in all phases of program design, implementation and evaluation. As and when Burma society continues to grow and evolve and natural networks of MARPs communities are formalized and strengthened, it will be important to engage community members in national decision-making processes.

3.4.5 Replication and sustainability

PSI/Burma’s strategic information and research portfolio has a good potential for replication. These SI and research activities are the foundation of any strong international public health program as the activities are directly linked back to program implementation and results are used for decision-making and program improvement.

The breadth and depth of PSI/Burma’s strategic information and research portfolio is advanced and currently has the luxury of being highly resourced (both human and financial). This type of SI structure probably has less potential for replication since it is unique.

Regarding sustainability, the foundation of integrating SI and research with program planning and implementation is critical and is a model that is sustainable in any disease/public health area and should be something that all programs endeavor to achieve.

3.5 Program management

3.5.1 Outline of program management

PSI/Burma is a large organization, employing over 700 people. A significant number of staff are engaged in field work. PSI/Burma’s head office is in Rangoon, and there are 14 other offices throughout the country. The organizational structure of the head office consists of six departments reporting directly to the Executive Director. Those departments are Programs Support, Strategic Information, Social Marketing, Social Franchising, and Finance. In addition, there is a Special Advocacy Team and a Finance Monitoring Unit.

The TOP is part of the Social Marketing Department but operates with a significant degree of autonomy, which is reinforced by TOP staff not being located in the head office. PSI has been comfortable in supporting a peer driven model for TOP, with suitable accountability checks and balances.

3.5.2 Key achievements

Increase access to prevention interventions for MARPs

All peer human resource management system

PSI/Burma uses an innovative “peer progression model” to recruit, train, promote and retain peer employees to work in TOP. All positions are recruited from peers and all promotions are filled by existing staff moving to higher positions. Capacity building is a strong element of this model. This is the foundation of the overall vision of a sustainable MARP–managed program. When employees feel invested in their work and feel passionate about serving their community, it shows in all levels of the performance of the program. A peer staffed Technical Support Unit has been established in TOP’s Rangoon base to manage the day–to–day technical support to all DiCs to lead the establishment of new DiCs. Creation of this Unit was necessitated by the rapid expansion in TOP. The TOP National Director stated that his role has changed over time from one of management and quality assurance into that of senior technical advisor.

Value driven

The core guiding principles of the TOP Program are: nothing for us without us; respect and protection; reducing vulnerability; effectiveness; and evidence to action. This MARP–centered approach allows PSI/Burma to be creative and think about innovative solutions to providing adequate and full access to services for MSM and FSW.

Innovation: FSW Emergency Fund

TOP’s FSW peer staff have come together to create a *FSW Emergency Fund* among themselves. Every week the peer staff contribute a small amount of their earnings into this fund. Interest free micro–loans with a flexible repayment plan are available to FSW peer staff from the Emergency Fund. To date, all loans have been repaid in full. This strategy is also employed by some of the PLHA Saturday Clubs to help with emergency needs.

Increase access to care and support for PLHA

Robust private sector health care model

PSI/Burma has created a successful, robust private sector health care model to expand and increase access to health services and products through the network of over 1,000 doctors in the Sun Quality Health Network, the Sun Primary Health Network of 776 community health workers, and through social marketing of health products through pharmacies and non-traditional outlets.

Improved enabling environment

Advocacy

PSI/Burma through direct advocacy and technical support was successful in advancing a focus on MSM HIV prevention services. In the 2003 Global Fund Round 3 grant, there was no MSM programming. PSI/Burma opened the first MSM DiC in 2004, with USAID support. As a result of

advocacy by PSI and others, the National Strategic Plan (2006–2010) included for the first time MSM as a priority MARP for the National AIDS Program.

3.5.3 Strengths and facilitating factors

Peer-led workforce and MARP engagement

There is a dedicated and skilled peer outreach, peer volunteer, and TOP Center staff. The peer model is the critical element that makes the program work because of their ability to penetrate their own networks and combine peer support and outreach services together with health information about STI and HIV. Members of the target communities are regularly engaged throughout strategic planning and implementation processes to ensure their needs are met.

Productive working relationship with MoH/NAP

PSI/Burma has worked hard to strengthen its coordination and communication with government entities at the local and national levels. PSI/Burma staff provide technical assistance to the NAP when requested. Links with local government health services are strong and allow for efficient functioning, including sending blood, without names, to government laboratories for HIV testing. (Rapid testing is only conducted at the Rangoon and Mandalay DiCs.)

Collaboration with other key stakeholders

PSI/Burma appears to have good collaborative relations with other key stakeholders in the country to coordinate and strengthen access to care, support and treatment for PLHA.

3.5.4 Challenges and barriers

Collaboration with other USAID CAs

The relationship between TOP and the Alliance's MSM program is strained. There is a need for both organizations to make a concerted effort to improve collaboration. There is some overlap in HIV prevention programming in MSM between the large PSI program and the Alliance's program in Rangoon and Mandalay. As the numbers of MSM reached by the Alliance are quite low, this overlap is negligible. Much better collaboration exists between PSI and Pact.

Coordination and transparency

There is a clear need for stronger coordination, communication, and transparency at all levels on the part of USAID and its partners with all of the in-country key stakeholders, which will help facilitate better collaboration and transparency of programming. This is due, at least in part, to the continued difficulty in USAID obtaining visas to enter Burma for program monitoring.

3.5.5 Replication and sustainability

As mentioned previously, PSI/Burma has a vision of sustainability built into how they designed the TOP Center DiC model, which could at some point when conditions are right in Burma become independent and transition away from PSI/Burma to stand alone as a local NGO. Already, the TOP model has been replicated throughout the country with much success and in the future there are continued expansion plans using Global Fund and other donor funding.

Although the ongoing involvement of the private sector in HIV and other public health programming is currently significantly reliant on PSI support, at a minimum this private sector engagement provides a foundation for sustainability. Specific strategies to enhance sustainability are needed. PSI/Burma believes that its private sector health model is a sustainable, longer-term vision to health development as it can provide sufficient scale and efficiency in the delivery of

health services. Sustainability is also achieved through community ownership of programs, local partnerships, capacity building and technical assistance. This type of private sector health model is aligned with and supports national strategic plans and is not a parallel system. PSI/Burma believes that this type of private sector model is a viable health programming solution in fragile states and complex political environments.

3.6 Burma: TB program

Burma is one of 22 countries that account for 80% of global TB cases. TB is Burma's second national priority disease. Multi-drug resistance is found in 4.5% of all new TB cases. The HIV seroprevalence rate among TB patients is 11%.

3.6.1 Outline of the Burma TB program

In Burma a large percentage of health services for the poor are provided through the private sector, including 6,000 private doctors. Diagnosis and treatment of TB by private doctors is hampered by the cost and lack of knowledge and skills. In 2004, PSI Burma introduced a social franchising program for TB into its existing franchised network of Sun Quality Health (SQH) private general practitioners.

Participating doctors receive an initial three days of training from PSI along with regular training updates. Quality assurance is provided by visits to SQH clinics by PSI medical staff and monitoring and evaluation is undertaken by PSI Burma's head office. PSI has developed a well designed patient record form to monitor the program, and data is reported to the National TB Program. Participating doctors are provided with free, branded drugs in complete-treatment packages which in turn are provided free of cost to patients. The drugs are provided free of charge by the National TB Program. SQH doctors provide their services free of charge to patients, with no reimbursement by PSI. Laboratory diagnostic costs are reimbursed by PSI. PSI television advertisements promote TB treatment. In 2009 advertisements were aired 856 times. PSI also used print media and radio.

In 2010 the Sun Primary Health (SPH) network joined the TB program. SPH community health workers are involved in case finding and treatment support at the village level. This has potential to increase the number of patients seeking treatment and to reduce the patient defaulter rate.

Cash incentives are provided to poor patients with the aim of reducing the patient defaulter rate due to the inability of poor patients to afford transportation costs. The equivalent of US \$36 is paid in installments over 10 visits to treatment compliant patients. In 2009, around 8% of patients received cash incentives. PSI has set a limit of 10% of patients receiving cash incentives. The objectives of the incentive scheme are to encourage adherence to treatment, prevent the occurrence of interruption and default, reduce the economic burden on poor patients (e.g. time off work to see the doctor and transport costs), and increase the smear conversion rate and cure rate. Initially the incentive was trialed at \$12 per patient and only available through some clinics. There was a low uptake rate as some SQH doctors said the paperwork was not worth the amount of effort for that level of incentive. In July 2008, as additional donor funding became available, the incentive was increased to \$36 and expanded to potentially include all participating SQH doctors. An additional transportation fee for rural patients, paid on arrival for scheduled appointments, was also introduced. Nutritional support is available on an ad hoc basis for registered patients, depending on donations.

3.6.2 Key achievements

In the six years 2004–2009 a cumulative total of 52,700 TB patients were treated, with increases in the number of TB patients treated in each year. Currently the PSI TB program is treating around 12,000 cases of TB per year, which is 10% of total national cases. The number of SQH doctors actively involved in the program has grown each year. By the end of 2009, 676 SQH doctors in 145 townships were involved in the TB program which is the equivalent of 67% of all SQH doctors.

In 2008 there was only a small increase in the number of new TB patients despite an increase in the number of doctors participating in the program. From early 2009, PSI introduced an incentive of US \$2, paid to doctors for newly registered cases. This has resulted in an increase in new patients.

WHO's target for TB treatment success is 85%, with a patient defaulter rate of 5% or less. In the first year of the program the treatment success rate was 78%. In 2009 the treatment success rate reached 85%. Defaulter rates for the whole program have been at 6% for most years, but went up to 7% in two years. In 2007 and 2008 the defaulter rate for the overall program was 6%. Preliminary data shows that the defaulter rate for incentive cases reduced from 5% in 2007 to 3% by the end of 2008 after the level and coverage of incentives was increased. In the absence of increased incentives, the defaulter rate would most likely have been higher. However, it is too early to tell whether the incentive scheme will succeed in getting the overall program defaulter rate below 5%. PSI has speculated that to achieve a defaulter rate of 5%, it may need to increase the coverage of incentives to 20% of poor patients. More SQH doctors would need to participate in the incentives scheme to achieve this coverage level. While this would significantly increase program costs, this needs to be weighed against the very high cost of MDR treatment.

The program requires SQH doctors to routinely recommend that all TB patients have an HIV test. As private doctors are not permitted to conduct HIV tests this requires referral to a public sector site, with the exception of Rangoon and Mandalay where PSI has permission to operate two community VCT sites called QC clinics. The number of SQH TB patients having an HIV test in Rangoon and Mandalay increased from 5 to 24% between 2008 and 2009 following the introduction of an incentives scheme that pays US\$1.50 to the patient, on arrival at the PSI QC clinic, for transport costs. The SQH doctor is also paid \$1.50 for each TB patient who returns with a voucher from the QC clinic. Out of 1,260 TB patients who were HIV tested at QC clinics from January to October 2009, 243 (19%) were HIV positive. The cost of incentives paid to identify one additional TB/HIV co-infected patient was \$15.83. Outside Rangoon and Mandalay, PSI indicates that the HIV testing rate among SQH TB patients is very low.

3.6.3 Strengths and facilitating factors

The use of transport incentives and payments to doctors has been successful in motivating higher referral rates and attendance at VCT clinics in Rangoon and Mandalay. PSI is exploring options to provide incentives for HIV testing and counseling through public sector providers.

A very positive feature of the program is that doctors are prepared to give their services freely. As these doctors benefit from being a part of SQH, this may be a beneficial effect of social franchising.

SQH doctors provide information to the family members of TB patients regarding drug adherence and are active in providing information to communities to reduce stigma and discrimination. Many of the SQH doctors have also initiated their own TB outreach programs to follow up with patients who interrupt treatment to increase their compliance. In 2006, PSI took responsibility for paying these outreach workers.

The SQH TB program appears to be well managed and monitored by PSI. The program has been modified on a number of occasions with good results in terms of increased treatment success rates and fewer defaulters.

3.6.4 Challenges and barriers

National policy restriction on who can conduct HIV testing means that SQH doctors need to refer all patients to external providers. PSI is advocating for permission to provide routine opt-out HIV counseling and testing for TB patients at all SQH clinics. It will be difficult to significantly increase HIV testing rates for TB patients while the current policy restriction remains.

Around one-third of doctors are currently participating in the incentives scheme, although all are now able to join component of the program. Some doctors have been reluctant to provide cash incentives to eligible poor patients as they need to wait some time for reimbursement from PSI. The managers of the program would like to provide doctors with a cash float for payment of incentives. However, this has not been permitted by PSI for reasons relating to accountability and financial risk.

Follow up with defaulter patients has indicated that reasons for default included family problems, health problems, migration in conflict zones and alcohol dependency. While the incentive scheme has reduced the defaulter rate, incentives were not always able to overcome these reasons for default.

3.6.5 Replication and sustainability

The average case load of each cohort of trained doctors is stable. This is a good indicator of continuing commitment to the program by doctors and will assist with sustainability. The absence of fees paid to doctors may mean that TB treatment services would continue to be provided by general practitioners should donor funding cease. However, a number of costly aspects of the program would need to cease.

Table 4 sets out the cost per patient treated for the years 2007, 2009 and 2010 in relation to the package of services, incentives and other program enhancements. As additional elements have been added to the program, the cost per patient treated has doubled since 2007. There was a small increase in the treatment success rate in 2009. The impact of the revised and expanded incentives scheme and including SPH in the program in 2010 on treatment success rates are not yet known.

Table 4: Cost of TB treatment and effectiveness: 2007, 2009 and 2010

Year	Cost per patient	Tx success rate	Program package
2007	\$26	83%	Free treatment and diagnosis SSM, CXR
2009	\$37	85%	Plus cash incentives for doctors and adherent patients + nutritional support
2010	>\$50	?	Plus Sun Primary Health CHW case finding + support

Source: PSI Burma

The SQH TB program has demonstrated that providing large scale free DOTS using a socially franchised network of doctors is viable. This private sector model has particular applicability to Burma given the weakness of public sector health system and restrictions on donor funds flowing to government. The model may have applicability to other countries where these factors do not apply, as utilization of private sector medical practitioners increases reach and potentially coverage. Currently there is insufficient data to indicate whether the current configuration of the incentives scheme will be effective in driving the overall program defaulter rate below 5% and in increasing the treatment success rate. The program is still in a model development and testing stage. National program coverage and increased access to TB treatment have improved equity and treatment outcomes for the poor. The cost per patient treated is high and has grown as additional components were added to the program. The benefits of the program need to be balanced against cost and the implications cost have for sustainability. Further model testing should provide answers in relation to costs and benefits.

4. China

4.1 HIV prevalence in China

HIV prevalence among China's general population is estimated to be 0.5 percent, with highest levels in the six provinces of Yunnan, Henan, Guangxi, Xinjiang, Guangdong and Sichuan. HIV in China is concentrated in certain MARPs: IDU, FSW, and MSM. Over 40% of HIV infections in China have been among IDU. Surveys of hotspots found HIV prevalence among FSW at 5–10%, with the highest prevalence in Guangxi, Xinjiang, and Yunnan. Some FSW are also IDU, and thereby dually at risk. Results from a recent sixty-one city, Government of China survey found an average HIV prevalence rate among MSM of 5%, with rates as high as 18% in some cities. Key risk factors targeted by USAID/RDMA implementing partners in China include low condom use among MSM and low-income FSW, low condom use by MARPs with regular sexual partners, high rates of sharing needles and syringes among the IDU population, and low personal risk perception among MARPs.

4.2 Overview of PSI/China program

PSI/China implements HIV and malaria programs. HIV activities are exclusively USAID-supported (apart from one-time support from UNFPA in FY09 for the provision of technical assistance in social marketing.) Malaria activities are exclusively supported by the Global Fund Round 5 grant. PSI/China also implemented a one-year safe water program in FY09 through a public-private partnership with Proctor and Gamble.

With USAID/RDMA HIV funding, PSI/China supports the Comprehensive Prevention Package (CPP) through an integrated China work plan, in collaboration with other USAID/RDMA-supported cooperating agencies (CA)—Family Health International (FHI), the International HIV/AIDS Alliance (Alliance), the Health Policy Initiative (HPI), and Pact. Together, the USAID CAs contribute to the implementation of the overall Comprehensive Package of Services (CPS) model which includes the continuum of prevention, care and treatment. PSI's role within this integrated program is focused on model development through implementation of innovative approaches to HIV behavior change and prevention for IDU and FSW populations, and the collection and analysis of strategic information to monitor and guide program implementation.

PSI/China implements HIV interventions which target IDU and FSW in Kunming, Gejiu, Mengzi, and Kaiyuan in Yunnan Province; and Nanning, and Ningming in Guangxi Province. HIV activities in Yunnan began in 2003 and activities in Guangxi began in March, 2009. Specifically, these activities include:

- Highly targeted social marketing of HIV risk reduction products including male and female condoms, and lubricant;
- Targeted behavior change communications (BCC), and peer outreach with IDU and FSW through drop-in centers and outreach, plus limited technical assistance to MSM;
- Drop-in centers that provide a safe space for FSW and IDU;
- Mid and mass media communications for general HIV knowledge and reduction of stigma and discrimination towards MARPs;
- Referrals and linkages to allow MARPs to access a full range of prevention, care, and treatment services (CPS model);
- Capacity building of local partners, grassroots NGOs and the GFATM project sites for replication of successful interventions;

- Project level behavioral tracking among MARPs; and
- Routine behavioral tracking among MARPs in multiple USAID hotspots where CAs implement (with collaboration from other CAs).

PSI/China collaborates closely with two Chinese government organizations—the Public Health Bureau (PHB) and the Public Security Bureau (PSB). The PSB is a law enforcement agency responsible for the compulsory detoxification centers for IDU, making it a key government collaborator when working with the IDU population. The PHB supports health and other clinical services.

The PSI/China program utilizes a different approach from other PSI country programs. In addition to direct implementation by PSI, sub-grants are also provided. This includes two sub-grants to grassroots CBO-type organizations in Yunnan, (Sunshine Home in Kaiyuan and Kangxin Home in Mengzi), both implementing activities for IDU, and three sub-grants to local government in Guangxi (Nanning CDC, Ningming CDC, and the Wangzhou Community Center) for IDU community rehabilitation activities. The Wangzhou work includes support to the Nanning PSB for implementation of a pilot community rehabilitation project.

4.3 Prevention

4.3.1 Outline of the PSI/China HIV prevention program

PSI's HIV prevention program targets IDU and FSW with the provision of BCC interventions and other services. BCC interventions focus on decreasing sharing of needles and syringes and increasing consistent and correct condom use with commercial, casual and regular partners. PSI is engaged in condom social marketing on a limited scale (i.e., not marketing directly to 'non-traditional' and other outlets, but rather distributing PSI branded condoms through peer education and outreach activities).

PSI's prevention work includes peer education, community outreach, drop-in centers, support groups and health referrals. Peer educators engage IDU and FSW about the risks of injecting, the importance of consistent and correct condom use, the promotion of HIV counseling and testing, and the need for STI screening. Peer educators also work at the methadone maintenance therapy (MMT) clinics and detoxification centers. Peer educators use a variety of interpersonal visual aids such as flip charts and leaflets to deliver health messages.

Drop-in centers for IDU (Huxianghao Ba in Kunming) and for FSW (Sisterhood Health Home in Mengzi) provide a 'safe place' for IDU and FSW to meet and receive BCC messages, access to VCT and STI services, information on safer drug injection and access to low-cost condoms. PSI DIC are staffed by trained peer educators.

PSI has been successful in establishing a model site in Kunming (Huxianghao Ba) for community based rehabilitation of IDU. Using Huxianghao Ba as a learning site, PSI is beginning to adapt and replicate the model in other sites, beginning with the Wangzhou Community Center in Nanning. PSI supports peer education in eight of Yunnan's compulsory detoxification centers in collaboration with the PSB/ Narcotics Control Committee Office.

4.3.2 Key achievements

Development of best practice prevention models: drop-in centers and peer education

PSI's two drop-in centers promote the consistent use of high-quality/low cost, branded condoms with all sexual partners and encourage and facilitate testing for STIs and HIV. Interventions are based on a peer education approach, with support from IDU volunteers and peer educators.

The Huxianghao Ba Drop-in Center in Kunming provides a variety of services to its nearly 5,000 members, including confidential VCT services (pre- and post-test counseling and rapid HIV screening) with referral support to CDC for positive test results; referral to needle exchange services, methadone maintenance therapy (MMT) and detoxification services; home visits for peer counseling; IDU family member support meetings; community outreach and technical support including outreach in five MMT clinics, and peer educator (PE) supervision in detoxification centers. Huxianghao Ba Drop-in Center PE provide support to community rehabilitation programs in Kunming.

Efforts are made to contact hidden IDU through outreach activities and draw them into the center. Huxianghao Ba Drop-in Center cooperates with seven pharmacies to provide clean needles and syringes to active IDU. Narcotics Anonymous meetings are held once a week, supporting IDU to stay off drugs. Huxianghao Ba also cooperates with the Law College of Yunnan University to provide legal assistance to IDU and PLHA. When members fail to visit Huxianghao Ba Drop-in Center over two to three months, the center contacts members by phone to check on them and urge them to attend.

PSI peer educators working through the Sisterhood Health Home in Mengzi conduct outreach activities four times per week in identified 'hot spot' areas of Mengzi. PE report that they are reaching 'at least 90%' of known FSW, including both those based at entertainment establishments and the more hard to reach, street-based, low-fee FSW. Based on interviews with member FSW, an excellent rapport between PE and FSW appears to have been created.

The basic PE encounter includes the delivery of information on VCT, STI testing and sale or distribution of condoms. When making new contacts, PE encourage FSW to access the Sisterhood Health Home and its services. The center offers free medical examinations once a week by a doctor from the MCH hospital, with referrals to local health care services, and a VCT service twice a month. The center is able to track FSW by phone/SMS, alerting them to center-based activities or reminding them to have health examinations/tests.

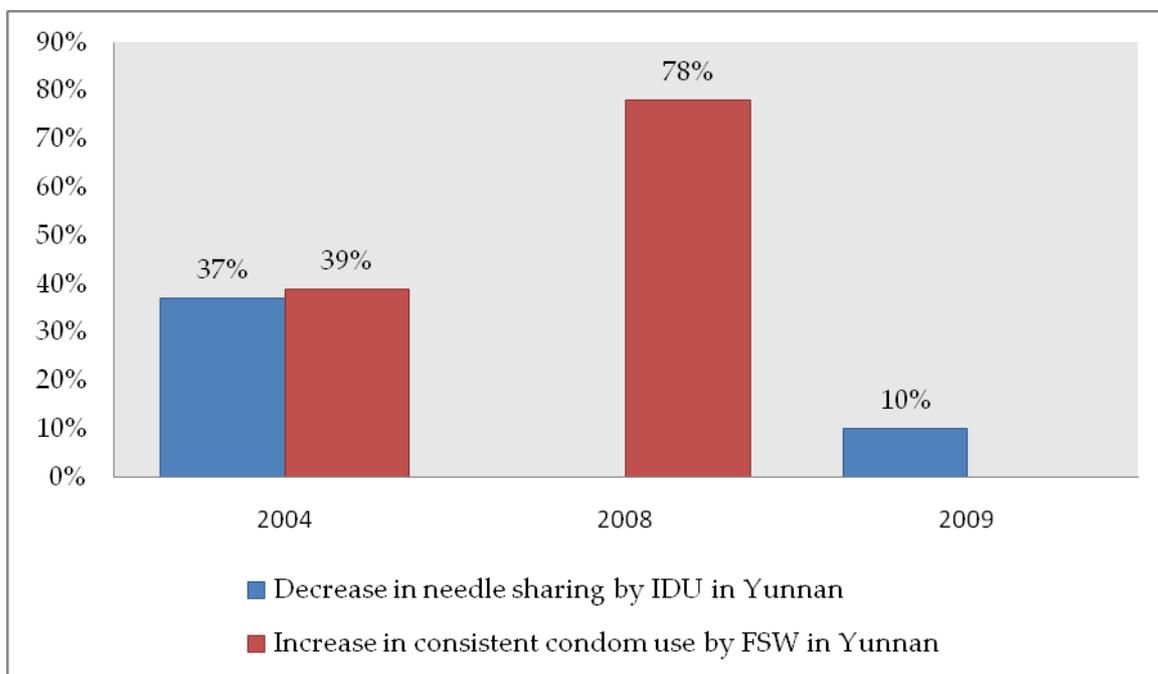
Both the Huxianghao Ba Drop-In Center in Kunming and the Sisterhood Health Home in Mengzi report that they have a good relationship with their community and neighbors. The community 'admires' their work, acknowledging that they are providing a service to the community.

As a testament to the effectiveness of PSI's BCC interventions, numerous individuals—both government and NGO partners—recommended that interventions be replicated in other 'hot-spots' in China. In particular the drop-in center model was highly appreciated. Many felt that the government would welcome the roll-out of the PE and outreach approaches developed by PSI and utilized by the drop-in centers.

Behavior change

Program strategies being implemented are helping to change key behaviors related to condom use, safe injection practices and uptake of HIV counseling and testing services. Both PE and beneficiaries claim that rates for safe behaviors have increased as a result of the work carried out by PSI (Huxianghao Ba Drop-in Center in Kunming and the Sisterhood Health Home in Mengzi). Needle sharing in Yunnan dropped from 37% in 2004 to 10% in 2009.¹⁰ Among FSW, consistent condom use with all partners increased from 39% in 2004 to 78% in 2008.¹¹ (See Figure 3 below.) Rapid testing at PSI DiCs increased from an average of five per month in December 2008 to over 25 per month in August 2009 (following introduction of rapid testing services in April 2009). In addition, the Guangxi Prevention and Treatment of HIV/AIDS Committee Office reported a decrease in needle sharing and indicated that condom distribution has been effective in reducing HIV and STIs.

Figure 3: Behavior change among IDU and FSW in Yunnan, 2004 – 2008/09



Source: PSI/China

Progress in reaching hard to reach populations

Both the Huxianghao Ba Drop-in Center in Kunming and the Sisterhood Health Home in Mengzi have been able to increase MARP access to prevention services. PE, outreach staff and PSI indicated that there is now less interference in their work from community members, government officials and police. According to government staff interviewed, these 'hidden groups' are extremely difficult for government to contact, let alone influence in any positive way. The role of PSI and other international NGOs is acknowledged as being critical to reach out to and influence hard to reach populations.

PSI has been successful in contributing to the intermediate result of "increased access to prevention services." During FY2007, (the year preceding the extension of this project), a total of 10,919 IDU were reached through peer education and outreach activities in Yunnan. PSI

¹⁰ TRaC Surveys in Yunnan Detoxification Centers (2004 and 2009)

¹¹ TRaC Surveys among Mengzi FSW (2004 and 2008)

increased this number to 15,365 in FY2009. In FY2007, a total of 2,662 FSW were reached through peer education and outreach interventions in Yunnan. This increased to 3,371 in FY2009 ¹².

A mix of traditional and evolving strategies

PSI's behavior change strategies can be described as a mix of 'traditional' and 'evolving'. The traditional approach involves the use of PE in drop-in center based and outreach activities in which information is delivered orally and via IEC print materials. As for an evolving approach, this is linked to the 2008 drug law which provides for the development of community rehabilitation for IDU. This new community approach, which involves work with government officers, IDU and the family of IDU, seems to be well received.

MARP involvement in developing behavior change strategies, messages and materials

In the development of strategies, messages and materials, PE, IDU and FSW involvement is significant. Determinants of behavior are drawn from TRaC survey results and used to develop key behavior change messages. IDU and FSW are engaged to make recommendations on messages, material content and overall design. Draft materials, designed by an ad agency/graphic design firm, are pre-tested with the relevant MARP and PE.

Overall NGO and government partners who use PSI IEC materials are pleased with their content and quality; MSF indicated that PSI produces 'good materials on MMT, safe injection and relapse'.

Improved availability of prevention products

PSI has contributed to improved access within the private sector for HIV/STI preventive products (condoms and lubricant) and has improved availability and access for MARPs to these products. Previously PSI handled retailing of branded condoms and lubricants to traditional outlets such as drug stores and supermarkets. However, as China now has a mature condom market with more than three hundred manufacturers and around 1,000 brand names, PSI made a strategic decision to shift to a modified social marketing approach, described below.

The general population in Yunnan and Guangxi have good access to condoms, including an array of domestic and imported commercial brands and free products distributed by the government. By PSI's account, the quantity of condoms in project areas is sufficient to meet existing demand. However, it is important to point out that there is very little hard data on the overall condom market in the project provinces.

PSI feels that their initial introduction of subsidized, high-quality, socially marketed condoms helped to influence the condom market in Yunnan, resulting in a greater variety and number of condoms and improved quality, with most now displaying ISO certification. MARPs interviewed confirmed the availability, affordability and quality of condoms available through the private sector. PSI's condom promotion interventions have had the most impact on MARPs and ethnic minorities. The social marketing approach has increased the target group's understanding and desire to protect themselves. MARPs are now willing to pay for condoms in China.

PSI now works with a 'marketing/distribution' company (via Futures Group) to place PSI branded condoms with display materials in 2 to 5 star hotels in project areas. In addition, PSI collaborates with other organizations (FHI, Alliance, MSF, GFATM, AusAID, Clinton and Gates), providing them with subsidized, branded condoms—30% are distributed for free and the

¹² PSI/China Annual Reports FY2007 and FY2009

remaining 70% are distributed via low-cost sales. PSI also provides branded condoms to the local CDCs. PSI trains staff in social marketing. CDC 'peer educators' undertake direct distribution of condoms through 'non-traditional' sites for FSW and other MARPs. In addition, PSI peer educators distribute condoms at their drop-in centers and during outreach activities.

Table 5 – Subsidized social marketing of condoms/lubricants – cost/income: 2007–2009

	SALES REVENUE*			
	Jan–Dec 07	Jan–Dec 08	Jan–Dec 09	TOTAL
Condoms–Male	336,046	428,177	497,925	1,262,148
Condoms–Female	0	615	1,473	2,088
Lubricants	7,797	60,397	18,305	86,499
<i>Total sales revenue</i>	343,843	489,189	517,703	1,350,736
<i>Expense</i>	COSTS*			
Local Salaries	115,944	136,091	153,073	405,108
Travel	5,946	16,939	17,830	40,715
Product cost	236,754	290,264	308,528	835,546
Shipping and Handling	6,505	6,628	8,363	21,496
Total Expenditure	365,149	449,922	487,794	1,302,865
SURPLUS/(DEFICIT)	(21,306)	39,267	29,909	47,871

* Currency is in RMB. US \$1 = RMB 6.8. Source: PSI/China

Income from PSI/China condom social is relatively small. The program is still largely subsidized to cover operational costs as well as human resources. PSI/China uses income generated from social marketing activities to procure additional commodities and to support distribution costs.

4.3.3 Strengths and facilitating factors

Strengths and facilitating factors include:

- A highly skilled and committed group of peer educators and volunteers working through the highly popular PSI drop-in centers. The PSI model combines peer support and outreach services together with health care to address the needs of recovering IDU. This is a model that warrants replication throughout China.
- A supportive and productive relationship with government partners. In all cases government officials (Health Bureau and Public Security) indicated they are pleased and impressed with PSI interventions and technical assistance. All indicated that the PSI approach is effective in reaching MARPs and that they would be unable to replicate the model on their own.
- Consistent promotion of VCT and STI services in BCC interventions, and availability of basic VCT, STI and referral services through the drop-in centers.
- PSI's access to and participation in community based rehabilitation at the request of local government.
- Links with local government health services (CDC, MMT) allowing for smooth, efficient and non-discriminatory referrals.
- Involvement of MARPs in the development of IEC resources and program interventions.

4.3.4 Challenges and barriers

While the PSI program has realized success in several areas, and has been recommended for replication in other areas of China, there remain some challenges and barriers that PSI and partners (government and NGO) need to focus on.

- Condom use by IDU and FSW with regular partners is still low (although there is no issue with availability of quality condoms). IDU and FSW are reluctant to approach their regular partners about condom use. They want to hide their past/current situation (i.e., as a sex worker or drug user) from regular partners. Attitude change will require a significant and sustained IPC approach.
- FSW feel that putting the onus on them for ensuring consistent condom use is not a balanced approach. FSW suggest that future HIV awareness and prevention interventions also focus on their clients. An independent set of materials and approaches will need to be designed to target clients in an effective way.
- Behavior change is a long-term process. PE must spend considerable time working personally with IDU to ensure/guarantee solid change. This will require a sustained commitment by both PSI and the government.
- While MARP involvement in material development is a notable achievement, it appears that new IEC materials have not been developed in the past one and a half to two years. Several PE and MARPs from both the Sisterhood Health Home and the Huxianghao Ba Drop-in Center indicated that new, innovative IEC materials needed to be developed. It was claimed that the FSW and IDU were 'getting tired' of receiving the same information on HIV over and over again. New materials need to contain information on topics other than HIV as well as try out new delivery systems (i.e., use of new technologies such as cell phones and the internet).
- Many MARPs are still reluctant to access VCT services, either for fear of receiving a positive result or concern with the name based, non-confidential system, given current Chinese policy.
- While the community rehabilitation program has helped to sensitize many about drug use and HIV, many IDU and PLHA still prefer not to reveal their status to partners/family. More counseling and psychosocial support, with links to care, support, and treatment, is needed
- MMT adherence could be improved. PSI is currently developing new IEC materials and approaches to work with IDU.
- Stigma and discrimination towards IDU, FSW and PLHA are still high among groups not touched by PSI and other partners. This may require the development and delivery of a creative and sustained mass media campaign focusing on the general population.
- Reaching migrant populations remains an issue. Innovative approaches and resources need to be considered.
- Members of the Huxianghao Ba Drop-in Center and the Sisterhood Health Home feel that centers need to 'diversify' their activities by offering job skills training (such as computer and office skills) and job placement assistance. Without such diversification the appeal of the centers may wane.

4.3.5 Replication and sustainability

There is concern regarding the replication and sustainability of PSI approaches. Undoubtedly the work carried out by PSI peer educators, volunteers and outreach workers is effective—indications are that condom use has increased, needle and syringe sharing has decreased and more individuals are accessing STI, VCT and MMT services. The community-based, MARP-friendly approach that PSI utilizes is essential to China. However, given that interventions are financially supported completely by PSI, sustainability and adherence to the model remains a question under potential government management. Can the government pay an equivalent salary to PEs, and more importantly, will PEs trained by PSI be allowed to work in a creative and supportive environment with the government? USAID needs to take these concerns into consideration when planning for replication.

It is clear from interviews with government officials that sustaining the PSI model would be difficult for both financial and methodological reasons. PSI brings a level of ‘humanity’ to the PE and behavior change process which the government may not be able to replicate. Several government staff indicated that it would be ‘difficult to continue without PSI support’.

However, considering the enthusiastic support by the government for the PSI interventions and acknowledging the growth and enthusiasm of Chinese civil society groups, it may be reasonable to imagine that the replication of PSI approaches could be attained via a partnership between the government and local civil society groups. Such a melding could help obtain international donor support and establish partnerships/working agreements with appropriate Government agencies. Beyond that, local civil society groups may, on their own or within an alliance of like-minded civil society groups, seek international and/or national donor support in order to replicate PSI approaches and programs. This approach may be more appropriate in continuing and potentially advancing the humanitarian approach practiced by PSI outreach teams targeting MARPs.

Most interviewees also commented that PSI needs to do a better job of communicating with government officials in order to increase visibility of this successful approach, to support the roll-out of the model to other areas of the country and to leverage financial support from government sources.

4.4. Strategic Information

4.4.1 Outline of key strategic information activities

PSI has a robust and multi-functional strategic information system in China. The monitoring and evaluation (M&E) system includes collection and analysis of data at all levels, from activity monitoring to outcomes. The following outlines the major activities for PSI/China’s M&E system.

Program level quality assurance

PSI/China adheres to quality assurance methods built into its data collection system that are standardized across all PSI countries. Protocols have been established for quality assurance in interviewer training, questionnaire translation, data collection, data entry and data cleaning. An example of data quality assurance for activity-level data from the Huxianghao Ba Drop-in Center includes monthly comparison of paper records with computer entries to ensure that the two match. Another example of data quality assurance for programs includes focus groups that are conducted when activity monitoring flags a possible issue in uptake of services. In terms of quality assurance for data analysis, given the poor data environment in China, results from population-level studies are triangulated with national surveys from the China CDC and UNICEF as much as possible.

Activity monitoring

PSI/China uses a web-based Health Management Information System (HMIS) to collect a variety of information on activities in their drop-in centers and for outreach activities. A client unique identification code is used to enable the identification of the number of individuals reached. Routine activities such as the number of visitors to the drop-in center, VCT visits and educational sessions are tracked in the web-based HMIS. Several pieces of information are recorded for each VCT client, including whether they received pre- and post-test counseling, test results, and what referrals were given to the client. In addition, information on support activities provided by peer educators in community centers, MMT clinics and detoxification centers is also collected. Trainings given and attended by staff are recorded in the HMIS, including technical assistance

provided to partners. A key feature of the HMIS is the tracking of referral cards given by staff compared with the referral cards collected from referee sites at the end of each month. This theoretically allows PSI to track how many of the referrals given are actually used. The web-based platform for the HMIS allows authorized users to enter information from any computer with internet access, whether at project sites or in the main office in Kunming. The HMIS is also programmed to build reports on selected items, thereby facilitating trends analysis and allowing for managers to quickly view the status and uptake of activities.

Routine behavioral monitoring (internal)

Tracking Results Continuously (TRaC) is the primary behavioral monitoring survey tool employed by PSI in the sites where it is implementing. It is designed to inform programming by the routine collection of data from targeted populations. PSI/China uses these surveys to provide information about the target population's behaviors, behavioral determinants, source of products and service delivery, and exposure to PSI's programs. TRaC also helps to measure the effectiveness of PSI's interventions and activities. The TRaC is performed by PSI/China's research team based in Kunming, with the help of interviewers hired locally. The data analysis is also performed by the research team in Kunming. Several TRaC surveys were undertaken over the course of the USG-funded project, with the goal of routinely tracking the behavioral outcomes of targeted IDU and FSW. TRaC surveys for IDU in Yunnan and Guangxi were performed in 2004, 2006, and 2009. TRaC surveys for FSW in Yunnan and Guangxi were performed in 2005 and 2008.

The *Routine Behavioral Tracking (RBT)* survey is another way that PSI, in collaboration with other CAs, will conduct behavioral monitoring in 2010. The purpose of the survey is to establish a baseline and a model for future surveys of the FSW and MSM populations in Yunnan and Guangxi, and to provide programmatic and behavioral monitoring information for USAID-supported interventions provided by multiple USAID-supported CAs in those provinces. Data gathered will be used to report against key monitoring indicators and to provide program donor and partner organizations with a comprehensive evidence base for further work with these populations.

In 2009, USAID requested that PSI take the lead role in developing the methodology and coordinating the RBT survey for USG-funded FSW and MSM programs in Yunnan and Guangxi, including those implemented by other cooperating agencies. PSI will take the lead role in measuring the reach and effectiveness of the FSW and MSM programs in program sites using a survey based on its TRaC tool and incorporating sampling and experience from other methodologies and data collection, such as the FHI's behavioral surveillance survey (BSS). The data gathered through the 2010 RBT survey will be analyzed according to PSI's Performance Framework, presenting results in the "Dashboard" format. The Dashboard is a set of standardized tables for segmenting populations, monitoring trends in key population and service delivery indicators, and evaluating program effectiveness. Data from the 2010 RBT will also provide a risk profile for MARPs. Results from the Dashboard analysis will be used in strategic project planning. It is envisioned that the RBT methodology may be adopted for measuring the effectiveness of the USAID-supported CPS model for MARPs in other countries.

Periodic outcome monitoring (external)

HPI will oversee an external assessment of the USG-funded IDU services in Yunnan and Guangxi and document the model for possible replication. The work will be undertaken via two simultaneous tracks, delivering preliminary results from both processes by June 2010. The full studies will be completed in September 2010. HPI sub-contracted with an international

consultancy firm to provide technical leadership, and a local Chinese research institute will support data collection. Track one will consist of a qualitative study of IDU services in USAID–support sites, with the following objectives, using an adaptation of the Appreciative Inquiry methodology:

- To describe the IDU model in substantial detail, including development of a collective view of the model, its inputs, outputs and outcomes, key indicators and influences on outputs
- To assess the achievements, strengths, shortcomings and weaknesses of the IDU activities in the framework of CPS implementation in Guangxi and Yunnan
- To develop, collectively with CAs, strategic recommendations to improve key IDU activities implemented in CPS.

Track two will consist of a risk behavior survey that will be an adaptation of a survey tool already available in Chinese. The study will make comparisons in risk behavior between CPS IDU service clients and non–clients and between sites where CPS IDU services are available and matched sites where no services are available.

Annual performance review

An annual performance review is conducted by PSI/Washington where the China program is compared to other country programs based on the use of a “dashboard” tool. This annual review also includes the possibility of incentives for country programs that are performing well compared with other countries where PSI has a program.

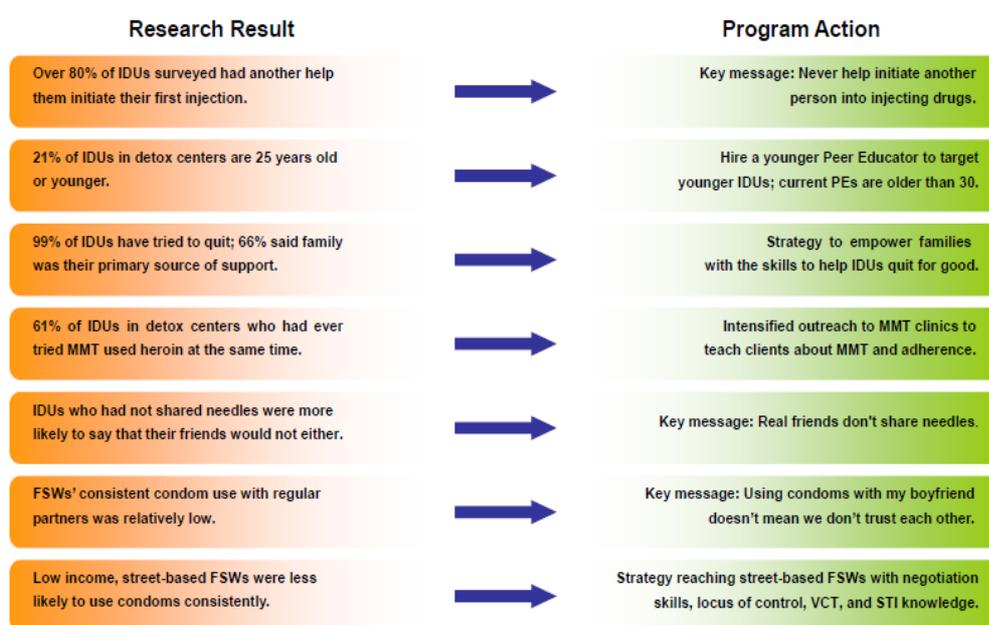
Surveillance

PSI/China does not participate in HIV surveillance activities.

4.4.2 Key achievements

- Through the TRaC survey and RBT described above, PSI/China collects information on *behavioral determinants* of the target groups. The collection of this information is an innovation in routine behavioral monitoring and gives insights to PSI for the adjustment of its program and changes in the target population’s needs. The RBT will enable this process to also include other CAs and enhance the integrated USAID approach.
- The TRaC also allows PSI to collect information that demonstrates *attribution* of improvements in health outcomes directly to PSI programs. The PSI China program was able to use TRaC survey data to demonstrate the effectiveness of its programs in increasing condom use among FSW, decreasing needle–sharing and increasing condom use among IDU, and increased uptake of VCT services due to PSI programs.
- PSI/China has taken a *leadership* role in the implementation of the RBT, which includes adapting the TRaC survey and coordinating other USG partners to provide excellence in behavioral monitoring for MSM and FSW in Yunnan and Guangxi.
- The PSI China program *uses data to make decisions* and change course in its program activities. Figure 4 below provides specific examples of how data was used to take action in PSI’s program.

Figure 4: Use of data to make decisions



Source: PSI/China

4.4.3 Strengths and facilitating factors

- PSI as an international organization places an *emphasis on evidence-based programming*. This provides a worldwide network of support for continued excellence in the collection and analysis of strategic information at the country level.
- The PSI/China team and PSI as an organization has a *high technical capacity* for undertaking research activities. All survey design and data collection can be completed by PSI's research team in China. There is a strong internal technical capacity that is mostly led by Chinese nationals.
- Through the TRaC and RBT surveys, there is *close monitoring of target populations*.
- In addition, the TRaC surveys allow for segmentation of target populations that tracks *behavioral determinants* for improving programming.

4.4.4 Challenges and barriers

- PSI/China faces serious constraints in contributing to the data base on HIV in China due to Chinese government policies and practices on sharing results of its annual HIV epidemiological surveys. Most data on HIV and MARPs is labeled as confidential by Chinese officials and, when results are shared, their validity cannot be verified. Data collection methods and survey questionnaires are not shared. In addition, external organizations must receive permission from the Chinese authorities to conduct any epidemiological research. Therefore, the reliability of data on the epidemic in China is uncertain.
- In addition to the relative lack of available data on HIV in Yunnan and Guangxi, the human rights situation in China, especially for MARPs, creates a more complicated environment for even the routine behavioral surveys undertaken by PSI. MARPs are suspicious of participating in such surveys due to poor experiences with China CDC's surveillance methods. MARPs report being forced to participate in China CDC surveillance activities including the use of biomarkers, results of which are usually not shared with the individual.

- PSI headquarters requires PSI/China to collect information that is not always relevant to its program. This is a constraint on PSI/China's flexibility in designing and managing its own M&E system.

4.4.5 Replication and sustainability

- PSI/China's SI activities are not replicable without PSI technical assistance to develop the capacity of partners. Currently, all SI activities are undertaken internally by PSI staff.¹³
- The newly-initiated RBT will be jointly implemented by PSI and other USG-funded CAs. Despite some knowledge and skills transfer to the other CAs in the process of developing and implementing the RBT, PSI plays the leading role and it is as yet uncertain whether other CAs will be able to perform the RBT without PSI's assistance.

4.5 Program Management

4.5.1 Outline of program management

PSI has a total of 45 staff in China, 25 for the HIV program and 20 for the malaria program, with the main office located in Kunming, Yunnan Province. Staff in Kunming includes a Country Director, social marketing advisor, a training team, a technical team including experts on BCC and FSW and IDU programs, and a research team. The training team was established following the 2007 USAID award as there was a crucial need for dedicated training staff. PSI has identified and trained several peer educators who are essential to success of the program. These peer educators are paid a salary by PSI and are considered to be full-time PSI staff. In addition, PSI has a small office in Nanning (three staff) in Guangxi Province. Staff from PSI's Kunming office travel to Nanning every month to conduct trainings and project oversight. It was noted that additional staff would be helpful, particularly as staff turnover is currently high.

Unlike the PSI/Burma and PSI/Lao HIV programs, the PSI/China HIV program is exclusively USAID/RDMA-supported. PSI/China is planning to transition and close down activities as of September 30, 2010 when the current agreement with USAID finishes. The forthcoming end of this project and uncertainty of job security has affected morale and many staff have left PSI/China over the past several months. This has resulted in numerous vacancies and increased workload/fatigue among the staff that remain. In addition to the normal workload, PSI staff have been significantly involved in several USAID reviews of the China program over the past several months.

4.5.2 Key achievements

Development of a model learning site

PSI has been successful in establishing a model site for the community based rehabilitation of injecting drug users IDU in China. This site, the Huxianghao Ba DiC, is directly implemented by PSI in Kunming and has been branded and socially marketed as a package of services through a community led and implemented model for IDU. PSI has hosted study tours for government officials to visit and learn about the Kunming site and has provided on-site training by staff from Huxianghao Ba at potential new sites. A key achievement is that the Huxianghao Ba community model is currently being adapted and replicated by the government in Nanning and through this

¹³ It should be noted that the finding regarding the sustainability of PSI's strategic information activities in China is different from the findings regarding the sustainability of PSI's strategic information activities in Burma and Lao. This is because the strategic information activities in China are quite different to those in Burma and Lao.

process, is informing the implementation of the community based rehabilitation outlined in the June 2008 Anti-Narcotics Law. In this collaboration, the government finances the cost of the center and PSI supports the salaries and training of the peer educators who work to replicate the Huxianghao Ba model. While this partnership ensures greater government collaboration, there is a high level of fear and distrust (due to perceived stigma) among IDU in using a government-run center. PSI is assisting the government in marketing and designing the center to be more “IDU-friendly” and similar to their Huxianghao Ba learning site. In addition, other organizations, such as Day Top, have adopted and opened similar DiCs. PSI has been proven to be successful in experience sharing and learning in the model replication process.

Capacity building

PSI’s approach to capacity building and technical assistance in China as well as other countries is unique. The capacity of partners is developed through an approach of “leading by example” through direct implementation rather than short term technical assistance provided from a distance. PSI’s strategy for capacity building and long term approach to technical assistance, together with their evidence-based programming, has proven to be effective. For example, PSI was among the first INGOs to demonstrate to the Chinese government that the introduction of HIV rapid tests will increase uptake of VCT among MARPs and consequently, screening rapid tests have been adopted by the government in select sites over time.

Evidence-based programming

Using, their own TRaC methodology, PSI has quantitatively proven the impact of their programs to the government and has been asked to work in new areas. For example, PSI was the first INGO to be able to work *inside* the IDU detoxification centers. PSI has successfully partnered with the Guangxi Public Security Bureau (through a MOU) and collaborated with the Yunnan Public Security Bureau to be able to provide peer outreach activities and peer educator trainings inside the detoxification centers. PSI led the way and has provided technical assistance to AusAID and other NGOs on work inside the centers. Other examples of how PSI’s internal use of data has garnered more support include:

- UNFPA has requested technical assistance from PSI for the training of government staff in two provinces in the area of social marketing franchising.
- WHO has requested technical assistance from PSI on social marketing services and products. PSI is exploring future collaboration with WHO.
- AusAID has requested PSI technical assistance for training inside the detoxification centers.
- PSI secured Global Fund Round 5 monies for malaria. PSI’s high performance in malaria, along with targeted advocacy, was recognized by the Chinese government.

Community-driven program planning

PSI works together with local target communities in developing work plans. PSI believes that MARPs must be involved in the planning process to ensure that activities are relevant and appropriate. PSI also engages community leaders, family members and key individuals in program development and planning. PSI has developed excellent relationships with these individuals and organizations and they are comfortable approaching PSI directly regarding programmatic needs and changes.

4.5.3 Strengths and facilitating factors

Involvement of MARPs

PSI deploys MARPs as staff which has been a critical component of their success in China. Members of the MARP target population are engaged throughout the planning process, ensuring that the program is continuously redefined to meet their needs. For example, new facilities were added to the Huxianghao Ba DiC (weight room, baby room) at the request of IDU clients. As a result of this MARP-involved approach, PSI staff is considered as 'family' to the clients. The inclusion of IDU in rehabilitation activities has also helped to decrease stigma in the communities. PSI was commended by many government partners, for their exceptional ability to deeply penetrate into the MARP population.

Technical excellence

PSI's expertise lies in technical support in peer education, training and innovation in behavior change communication. PSI's work with the IDU community has been timely and responsive to the June 2008 Anti-Narcotics Law. The Chinese government and communities require considerable technical assistance in how to implement this law and PSI, as an INGO with expertise in the IDU population, is well suited to assist. PSI's technical training at the government-run Wangzhou Center has improved the relationship of IDU with the local community and family members.

Strong working relationships with strategic local government counterparts

PSI has developed strong relationships with the local government. Examples include:

- Establishment of an memorandum of understanding (MOU) with the Public Security Bureau in Guangxi and a technical assistance partnership in Yunnan, resulting in PSI's ability to provide peer education activities and training in the IDU detoxification centers in both provinces. PSI is the only INGO to have a relationship with the PSBs.
- Through a partnership with the local maternal and child health (MCH) hospital, PSI is bringing critical health services to FSW in Mengzi. A MCH doctor comes to PSI's Sisterhood Health Home DiC once a week, increasing access to health services among FSW and strengthening the link to government health services.
- In Nanning, PSI organizes regular project meetings in the Wangzhou community with the Public Health Bureau (PHB) and other INGO partners (MSF, etc) to coordinate on program planning, provide an update on project progress, and make future plans.

Collaboration with USAID/RDMA CAs

PSI's collaboration with the Health Policy Initiative, International HIV/AIDS Alliance (Alliance), and Pact has strengthened during the last two years. PSI and HPI have many complementary program areas related to IDU and harm reduction. Since the June 2008 Anti-Narcotics Law, PSI is leading on the implementation of community based rehabilitation for IDU, while HPI is leading on operational policy processes related to the law. There is also close collaboration on the IDU impact evaluation that HPI is undertaking and HPI's work on the establishment of a legal center, where PSI refers many clients. PSI, HPI, and the Alliance collaborate at the site level through their support to Kangxin Home, where PSI focuses on BCC training, Alliance on community mobilization and capacity building, and HPI on capacity building in the area of advocacy. PSI also collaborates with Pact on livelihood programs for IDU, where PSI refers clients to Pact's livelihood program. PSI's collaboration with FHI is weaker and noted under the challenges and barriers section below.

4.5.4 Challenges and barriers

CA collaboration

In 2004, in response to the request of the Chinese government to have one single point of contact for the USAID program, RDMA asked FHI to serve as the coordinator for all USAID CAs in China. The decision to have one CA to serve as the coordinator for other CAs, particularly a CA that has a key role in implementation, has proven to be problematic and resulted in a strained relationship between FHI and all the CAs. Collaboration among the CAs, not including FHI, is strong, but collaboration among the CAs and FHI is weak. This is not an issue that is exclusive to the PSI program.

PSI and FHI have both developed separate programs for FSW and IDU in China. There is no overlap at the site level as CA support to the sites is divided by hotspot. However, FHI and PSI should build on each others work on IDU and FSW programs in China and share experiences and information, such as IEC materials. Specifically, there is a clear opportunity for FHI and PSI to collaborate at the Jinhudong Green Garden Community Center for IDU in Geiju as PSI is providing outreach into the detoxification center near Geiju and can refer to FHI's community center. This collaboration has been initiated and should be encouraged.

There is a distinct benefit to a collaborative joint programming approach in the implementation of the comprehensive prevention package in China. However, there is a need for a neutral entity to serve in the coordination role. This should take the form of stronger USG coordination at the provincial level to ensure the implementation and integration of the program and clear delineation of each CA's role.

USG involvement in Beijing

There is a need for more USAID support at the national level in Beijing. In order for the USG to successfully move to a technical assistance model in China, USAID/RMDA must advocate and seek buy-in for the USG China CPP model with the National Center for AIDS and Infectious Diseases (NCAIDS), UNAIDS, and other donors. USG involvement in Global Fund mechanisms at the national level is required to advocate for provincial level Global Fund resources. PSI advocates at the provincial level to the extent possible, however, few resources are available at this level and decision making occurs in Beijing. Involvement by USAID CAs at the provincial level alone will not result in successful leveraging of Global Fund resources.

Communication with the provincial governments

More regular and proactive communication between PSI and the provincial governments needs to occur to ensure joint programming and collaboration. PSI's communication with the Guangxi HIV and AIDS government offices is minimal, however, it should be noted that the program in Guangxi is new.

PSI has a strong link to the PSB, however, a stronger communication mechanism with the Public Health Bureau (PHB) needs to be established. This appears to be a weakness for many NGOs in China. While PSI submits reports on a semi-annual and quarterly basis, as requested by the government, follow up meetings to discuss the reports, in addition to regular progress updates, are needed. It also appears that internal communication systems within the Chinese government may be weak as INGO progress reports are not routinely shared. Sharing of information between government offices (PSB and PHB) is difficult. Higher level of government engagement is needed

between PSI and the government so that the impact of PSI's program can be conveyed for advocacy purposes.

Limited focus on community involvement from the Government

Community mobilization and involvement is not central to the Chinese Government response to HIV and AIDS. The Guangxi government is more open to work with IDU and therefore is allowing PSI to work in local communities, whereas the Yunnan government is more closed. PSI successfully negotiated an MOU with the Guangxi PSB to help implement the June 2008 Anti-Narcotics Law, focusing on community rehabilitation. PSI has established a less formal technical advisory role in Yunnan, where they work in 7–8 detoxification centers and support community rehabilitation.

Management challenges

Due to turnover of PSI staff over the past year, the management of the PSI/Sisterhood Health Home FSW DiC is weak. PSI, in discussion with the FSW peer educators, enhanced the outreach component of the program and subsequently modified the hours of the DiC, so that it is only open 2 days week (Thurs–Friday). However, this has resulted in far fewer FSW participating in DiC activities (2–5 FSW/day compared to 10–15 FSW last year) as activities inside the center are often cancelled. FSW that were interviewed were unhappy about this change and felt that they no longer have a safe space.

4.5.5 Replication and sustainability

PSI builds sustainability through its focus on overall health impact and behavior change, based on disease area with an overall goal to improve quality of life. Those individuals who have been trained by PSI may continue to be involved in HIV work beyond the life of the PSI project. However, success in China is highly dependent on an enabling environment. An effective MARP-friendly response in China requires a quality assurance/technical assistance role provided by an NGO. There is still a large gap in technical capacity in HIV in China, particularly in the areas of community involvement and mobilization, capacity building, human resources, and innovations in approaches to achieve behavior change. There is a clear need for USAID to provide technical assistance in these areas as well as quality assurance to government funded programs.

In future, Huxianghao Ba can serve as a learning site from which technical assistance on implementing a community based rehabilitation program for IDU can be provided. However, if the PSI program ends, there will be no human capacity or enhanced technical capacity for the DiC. The Wangzhou Community Center will continue as it is supported by the government, however important technical innovations (peer education, training to government social workers) that PSI provides to help make the site more MARP-friendly will not continue.

Should USAID financial support end, it appears that the Mengzi government is willing to take over the PSI supported Sisterhood Health Home DiC for FSW, however county level resources for FSW programs in Mengzi are scarce. In addition, technical assistance through peer education and outreach training would be required for success of the DiC.

While PSI's employment of peer educators is key to the success of their program, it also presents an issue of sustainability beyond the support of an INGO. Due to budget constraints, the government is not able to provide a comparable salary to peer educators, making it unlikely that

the highly-skilled peer educators will work for a government program and thereby further build the capacity of the government.

5. Lao

5.1 HIV prevalence in Lao

Lao PDR continues to have low HIV prevalence in the general population, estimated at 0.2% in the 15–49 age group, despite being surrounded by countries with significantly higher HIV prevalence. Among MARPs, HIV prevalence rates are highest among MSM (5.6% in a 2007 study from Vientiane), and lower among FSW, who in the latest IBBS were found to have prevalence rates in the 0–2% range depending on the province.¹⁴ The potential for significant increases in these rates is demonstrated by high rates of STI infection that have been documented among FSW (30%) and MSM (40%).¹⁵

5.2 Overview of PSI/Lao program

PSI/Lao's main projects are:

- National condom and lubricant social marketing (CSM)
- HIV/STI reduction with MSM, focused on transgenders and their partners in Vientiane, Savanakheth and Luang Prabang
- HIV/STI reduction with sex workers in Vientiane and seven other provinces.
- Malaria reduction in three provinces
- A study to determine whether insect repellent reduces malaria incidence, taking place in 2 provinces
- Social marketing of other products such as water purification tablets

USAID support to PSI/Lao is only for its HIV program. In 2009, PSI received approximately \$1.3 million in total from a range of donors for its HIV program. Around 20% of these funds were from USAID, focused on HIV prevention with MSM in three provinces. With additional Global Fund Round 8 monies, USAID's contribution to PSI's HIV work will be reduced to around 15%. PSI's malaria funding is from the Global Fund.

5.3 Prevention

5.3.1 Outline of the PSI/Lao HIV prevention program

The PSI/Lao strategy is to focus its HIV work with MSM, FSW and clients of FSW, to prevent the spread of HIV. PSI/Lao has two specific evidence-based prevention projects: the *New Friends MSM/TG Project* and the *You and Me Project for Lao FSW*. This Assessment did not see or review the *You and Me Project* due to time constraints. The main focus of the Assessment's field review was the *New Friends MSM/TG Project*.

The 2007 MSM study which found a high HIV prevalence of 5.6% among MSM in Vientiane¹⁶, (the highest measured HIV prevalence in Lao), highlighted the lack of focused HIV programming for MSM. USAID/RDMA decided to segment responsibility for implementation of its MSM programming in Vientiane. PSI/Lao was to utilize its USAID funding primarily to focus on delivering a minimum package of HIV/STI prevention products and services to the visible transgender (TG) sub-population and the Burnet Institute was to focus its limited USAID

¹⁴ 2008 Lao PDR MoH Sentinel Surveillance Survey

¹⁵ 2008 Burnet, MoH/CHAS MSM/TG Survey

¹⁶ *Ibid.*

funding on programming with the less visible/hidden MSM with a masculine/normative male identity. At the time, this was a good planning strategy to avoid duplication of services and to increase overall access to different MSM sub-populations. Outside of Vientiane, PSI targets MSM more broadly attracting TG, their partners and other masculine MSM. Similarly, segmentation of the FSW target population happened between PSI/Lao (FSW at karaoke, hotels, nightclubs and guest houses) and FHI/Lao (FSW at drink shops).

New Friends MSM/TG Project

The PSI/Lao *New Friends MSM/TG Project* is aligned to support the Lao National HIV/STI Prevention Program. PSI/Lao used USAID funding to leverage additional support from the Global Fund and PSI's YouthAIDS Fund to launch three drop-in centers where MSM can access quality HIV/STI prevention services. The *New Friends MSM/TG Project* is carried out in Vientiane, Savannakhet and Luang Prabang. The project's target is for 1,200 Lao TG and 4,800 male partners in these cities to have increased access to VCT and STI services, pre-packaged STI treatment kits, and condoms and lubricants. The project aims to reduce HIV/STI prevalence through the following key activities:

- intensive peer-led behavior reinforcement campaigns (BCC) through three drop-in center (DiC) sites and outreach;
- targeted STI management and HIV VCT at DiCs;
- referral to HIV care, support and treatment services;
- social marketing of condoms, lubricants, and STI kits; and
- advocacy to reduce stigma

You and Me Project for Lao FSW

In Year 3 Implementation (1 Oct 2009–30 September 2010), PSI/Lao combined support from USAID and Global Fund to expand its outreach to FSW. Currently, the *You and Me Project for Lao FSW* is implemented in eight sites (Champasak, Savannakhet, Vientiane Capital, Vientiane Province, Luang Prabang, Udomxai, Sainyabuli, and Khammuan). Key prevention activities are similar to the MSM/TG prevention project and include:

- BCC activities on peer outreach;
- referral for clinical services (STI management and VCT);
- referral to HIV care, support and treatment services;
- social marketing of condoms, lubricants, and STI kits; and
- advocacy to reduce stigma

5.3.2 Key achievements

Increased access to prevention interventions for MARPs

Peer-led behavior reinforcement campaigns (BCC)

In January 2010, the *New Friends MSM/TG Project* was operating with 196 staff (both full-time staff and peer educators) in three cities. The major element of this HIV prevention program is a strong peer outreach component in all three intervention sites. PSI utilizes a "peer progression model" to engage community members in various roles ranging from field outreach peer staff to core DiC staff. Currently, almost the entire field and some of the core staff at the DiCs come from the target community. Primary exceptions are for technical specialists such as the clinic doctors, laboratory technician, and other technical and administrative positions. This commitment to the "peer progression model" contributes fundamentally to the creation of a space that is geared to a genuine sense of belonging for clients where they can receive and give support to one another

during outreach and at the DiCs. It is clear that peers are at the heart of creating a foundation where support for their community is central to building an environment where MSM interact with peers and other DiC staff to engage in health seeking behaviors in a way that leads to better health outcomes. The peer educators are trained and certified by the Ministry of Health's Center for HIV/AIDS and STIs (MoH/CHAS). Additionally, PSI/Lao provides more in-depth training as needed on special topics specific to the target population.

Peer outreach activities include: education and communication, IEC materials distribution, condom and lubrication sales, information about DiC, and most importantly friendship and community building. The peer outreach is conducted every night of the week in beer gardens, beer shops, salons, discos, other entertainment sites. Each peer educator has an assigned zone/hot spot. Peer outreach workers reported that they regularly meet repeat clients as well as new clients during outreach. The BCC messaging is grounded in HIV prevention basics for both repeat and new clients, with sessions for new clients taking longer than for repeat clients. With repeat clients, the sessions are more like conversations, with the opportunity to answer questions, which primarily relate to STI symptoms and VCT. Initial contact with clients are primarily made through outreach, with a significant number of clients subsequently visiting the DiC, especially in Luang Prabang.

PSI/Lao conducts pre- and post-BCC session tests with the target groups to monitor the quality of BCC sessions. In addition, mystery clients are sent to prevention outreach sessions, DiCs and clinical services to monitor the performance of these activities.

Additionally, PSI/Lao is on the cutting edge of development of innovative new BCC interventions for its MSM target population. In January 2010, PSI/Lao launched its new national project utilizing mobile phones to promote VCT and BCC.

Condoms and lubricant

PSI/Lao is the national leader in social marketing of condoms and water-based lubricant, with the support of the Global Fund. Condoms are widely available in pharmacies and non-traditional outlets near hot-spots (bars, discos, hotels, and guest houses). MSM and FSW condom use rates have risen. From 2004 to 2006, condom use for any sex in the last week by MSM went from 24% to 41%¹⁷. For the behavior, 'ever used water-based lubricant for anal sex' for MSM, use increased from 55% to 86%. Surveys of FSW showed similar increases in consistent condom use, except for consistent condom use with trusted partners, which decreased from 48% in 2005 to 46% in 2008¹⁸.

DiCs and targeted clinical service delivery

DiCs are another key element of PSI/Lao's HIV prevention program. In 2009, with combined funding from USAID, the Global Fund, and PSI headquarters, the *New Friends MSM/TG Project* opened three DiCs, thus significantly expanding access to quality HIV and STI prevention information and services for MSM, including TG. The DiCs also provide pre- and post-test counseling, rapid HIV testing, STI management and treatment, and referral to clinical care and ART services. DiC clinical services are provided by PSI/Lao hired medical practitioners. DiCs have created a safe place for community members, providing an environment for social interaction and community building. The DiCs also provides an opportunity for access to the

¹⁷ 2004 and 2006 TRaC MSM Survey; data from slide presentation given by PSI/Lao Director.

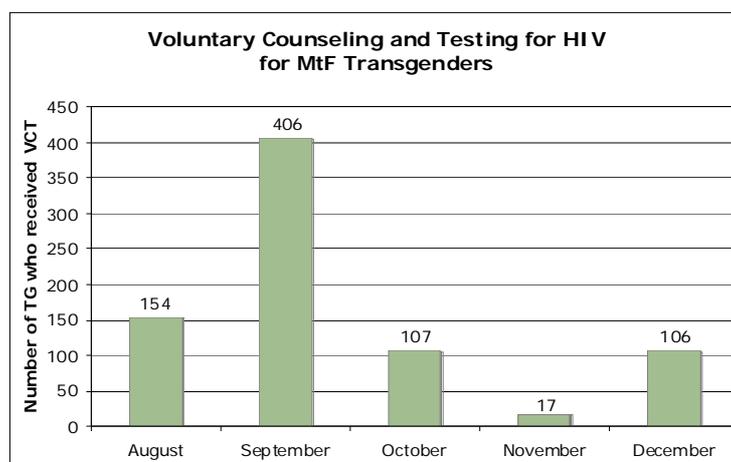
¹⁸ 2005 and 2008 TRaC FSW Survey; data from slide presentation given by PSI/Lao Director.

internet, entertainment, recreation, other information/education activities (i.e. small group discussions, skits, role playing, etc.) for a large number of MSM.

The 2008 size estimate for MSM was 15,000¹⁹. For the calendar year 2009, the *New Friends MSM/TG Project* reported reaching, through a combination of activities (outreach activities, DiC visits, and STI and VCT clinical services), a total of 7,296²⁰ individual clients. The total number of new clients was 4,443 (61% of all contacts). A total of 2,853 individuals were contacted on a repeat basis (39% of all contacts). The total of 7,296 MSM reached represents 49% of the estimated MSM population.

PSI/Lao was successful in obtaining approval from MoH/CHAS to conduct VCT rapid testing at their MSM DiCs. This is a significant achievement as Lao is one of the first countries in the region to allow rapid testing at DiCs, using the international standard two rapid test algorithm (Determine and Unigold). Figure 5, below, shows the number of MSM/TG having VCT by month at the three DiCs during the last 5 months of the 2009, when this service was introduced. A total of 790²¹ HIV tests were performed in the three DiCs, or an average of 154 tests per month. This exceeded PSI/Lao’s target of 500 tests by 290 or 140%. Use of a VCT incentive scheme for peer outreach workers seems to be a significant factor in the high rate of HIV testing. The incentive system pays \$20 to each peer outreach worker who brings in 1–10 people for VCT. The incentive doubles to \$40 to each peer outreach worker who brings in 11–20 people.

Figure 5: Targeted VCT for MSM/TG



Source: PSI/Lao

PSI/Lao data on MSM/TG utilization of STI clinical services at the three *New Friends* DiCs indicate a total of 121 clients received STI treatment in 2009. The breakdown of clients was 35 new TG; 1 repeat TG; 81 new partners; and 4 repeat partners²². These figures only represent those who received treatment. It is not clear from the data whether additional people are coming for an STI check-up but who do not need treatment. PSI/Lao uses a syndromic approach for the diagnosis of STIs. A more detailed analysis of the STI clinic data at the Luang Prabang DiC indicates that almost 100% of clients who attended the STI clinic presented with STI symptoms. If this is also

¹⁹ 2008 National Estimation Group, Size Estimation for MSM used in the Global Fund Round 8 application. Information provided by PSI/Lao via e-mail.

²⁰ PSI/Lao *New Friends MSM/TG Project* Monthly Report Jan–Dec 2009 Final (excel spreadsheet).

²¹ PSI/Lao *New Friends MSM/TG Project* Monthly Report Jan–Dec 2009 Final (excel spreadsheet).

²² PSI/Lao *New Friends MSM/TG Project* Monthly Report Jan–Dec 2009 Final (excel spreadsheet).

the case at other DiCs, clients are only coming for STI screening when they are showing symptoms. Given the limitations of the syndromic approach, it is unlikely that additional cases of STIs would be diagnosed if clients with asymptomatic STIs presented for check-ups.

The 121 clients who received STI treatment in 2009 is about 1.6% of the total number of individuals reached by *New Friends* in that year. The number of MSM/TG seeking STI treatment is considerably lower than the number seeking VCT (790 in the last 5 months of 2009). The experience in other countries in the region is that larger numbers of MSM seek VCT compared to STI check-ups. In Lao, the incentive paid to outreach workers for VCT may be the reason for the considerably higher numbers seeking HIV testing, compared to STI check-ups. However, as VCT only commenced at the DiCs in August 2009, the initial high utilization figures may not be sustained. It would not be feasible to introduce an incentive for STI check-ups using a syndromic approach as attracting clients with no symptoms would not result in a significant number of additional STI diagnoses.

PSI markets a single dose STI treatment kit ('One Stop' brand) for males through pharmacies, supported by the Global Fund grant. PSI trains pharmacies in the correct dispensing of this product.

The above analysis indicates that within a short period of time both the reach as well as service utilization by MSM has increased significantly in all of the intervention sites covered under *New Friends MSM/TG Project*. This success can be attributed to the process of community mobilization that *New Friends* has adopted as a core strategy. This process starts with the building of trust and confidences among peers, project staff, and the community members. The increased use of preventive services by MSM is also an indicator of strength of the peer outreach components of *New Friends*.

Increased access to care and support for PLHA

Referral to HIV care and support services and treatment

The PSI/Lao *New Friends MSM/TG Project* currently does not provide HIV care, support and treatment services at the DiCs. However, any HIV-positive clients found through VCT are referred to government clinics where ART is provided with Global Fund support. By January 2010, only three clients had tested HIV positive at the DiCs. All three clients were escorted and linked directly to government ART services, thereby ensuring a continuum of prevention to treatment for those PLHA. Care and support services are nascent in Lao and it is not clear who is providing these services. The Assessment Team concludes that the PSI/Lao program cannot adequately address or show results for increased access to care and support, as opposed to treatment.

Strengthened enabling environment

Advocacy to reduce stigma

PSI/Lao held the first "public forum" with Lao TG in December 2008. Members of the community and representatives from civil society and the public sector attended. It was reported by many peer staff and clients that because of the *New Friends MSM/TG Project* there has been a shift in people's attitudes toward MSM and TG. Clients say that the DiC is a place they enjoy coming to to socialize with their friends and they are successful in getting their partners to come with them to use the DiC's services. One program staff member reported that success for him is that the

members of the target communities trust the *New Friends MSM/TG Project* staff and they are open to having in depth discussions regarding HIV, condoms and sex.

5.3.3 Strengths and facilitating factors

Peer-led workforce and MARP engagement

The outreach and DiC components are the backbone of the program. PSI/Lao has dedicated and skilled peer outreach and DiC staff. The peer model is the critical element that makes these activities work. Peers have the capability of penetrating their social networks to access members of their communities and to combine peer support and outreach services with health information about STI and HIV. Members of the target communities are regularly engaged throughout the strategic planning and implementation processes of the program.

Prevention interventions are evidence-based

The *New Friends MSM/TG Project* BCC campaigns are evidence-based as PSI/Lao regularly conducts Tracking Results Continuously (TRaC) surveys to monitor behaviors and determinants of behavior and evaluate behavioral outcomes. There is good use of strategic information from these surveys which is directly linked to the refocusing (if needed) of BCC messages and the development of new, relevant, and nuanced BCC messages that better target the behaviors of the target population. Reports from focus interviews with clients suggest that the BCC messages provided during outreach are appropriate. (See 5.4 below for more on strategic information.)

Incentive scheme for peer outreach work

PSI/Lao uses incentives in two ways for outreach (using Global Fund resources) and for recruitment of people to VCT. In both instances, the incentive schemes have been successful in increasing client usage of the DiC and uptake of VCT. The incentive scheme should be continuously monitored and assessed for unintended consequences (see 5.5.3, Challenges and barriers, below).

5.3.4 Challenges and barriers

- Currently in Lao, there is no specific guidance on feminization issues for TG. Based on interviews with the clinical doctors at the DiC and a review of a draft external assessment report²³, there is a need for more training on the feminization issues for TG and their medical needs.
- USG Leadership: Strengthen USAID oversight and management of country programming. It was reported that increased monitoring trips and in-country support from USAID/RDMA would be welcomed.
- Condom use by MSM and FSW with regular partners is still low. There is a need to develop creative and innovative BCC/IEC approaches to address this.
- Uptake of female condoms by MSM is low. There is the option of promoting female condoms to MSM/TG, similar to what is being done by PSI/Burma. However, given the higher cost and therefore higher subsidy of social marketed female condoms compared to male condoms, this would increase program costs.
- Many MSM are still reluctant to access STI services. In particular, MSM who attend the STI clinic at the PSI DiC in Luang Prabang are routinely advised to go to the public sector STI

²³ Draft Report: External Review of the 100% Condom Use Programme and Sexually Transmitted Infection Services in Selected Sites in Lao People's Democratic Republic (June 2009)

clinic for syphilis testing. However, few do so because of long waiting times at the government clinic and the cost. Although the prevalence of syphilis in Lao is low, PSI should seek expert technical advice on whether rapid screening for syphilis should be introduced into its STI protocol.

- Stigma and discrimination towards MSM/TG, FSW and PLHA is still high.
- DiC activities could be diversified (e.g. income generating activities, job skills, English classes, etc.).

5.3.5 Replication and sustainability

PSI/Lao's *New Friends MSM/TG Project* is successful and there is a high degree of replication and sustainability for many of their HIV prevention approaches. The work carried out by PSI peer educators, volunteers, and outreach workers is effective and the community-based, MARP focused approach that PSI utilizes is essential for Lao.

The outreach incentive scheme is being promoted by Global Fund and will most likely be replicated in the future. The GFATM funding that PSI/Lao will receive will be sufficient to carry on this incentive scheme for outreach.

For longer term sustainability, there is a question as to whether the Lao government could ever take over a program like this since the funding for health and HIV are all donor based. The VCT incentive scheme has potential and has shown some early results in increasing the uptake of VCT by members of the community. As the project completes its final year on this grant, it will be important for USAID to monitor closely the results from January to September, 2010.

PSI/Lao is moving toward building a "total market for health products". PSI/Lao has been very successful in the social marketing of condoms, lubricant and STI kits. They are now trying to build a market for a broader range of prevention products that would be sustainable without long-term PSI support.

5.4 Strategic information

5.4.1 Outline of key strategic information activities

This sub-section reviews the strategic information activities contained in the PSI/Lao annual workplans for the period 2007-2010. An outline of these activities is Annex 5. The strategic information activities undertaken by PSI/Lao are similar to those undertaken by PSI/Burma. See section 3.4.1 above for an outline of these key strategic information activities.

5.4.2 Key achievements

Increased access to strategic information

PSI/Lao places a strong emphasis on improving its internal monitoring systems and use of the information collected for program planning and implementation, as well as disseminating best practices and evidence-based program information. Data flow from routine program M&E is logical to ensure a good continuous feedback loop of information to all levels of the program.

Project MIS System and data flow for the New Friends MSM/TG DiCs

Routine program data are collected through a Project MIS system. Client participation data are collected through paper-based systems by peer outreach workers and DiC staff. Clinical service data are also collected through paper-based systems by the staff doctors and laboratory technicians. Data are aggregated and cleaned on a weekly basis and entered into an excel spreadsheet by a staff member at each DiC. These data are reviewed on a weekly basis by the PSI/Lao DiC National Coordinator. If any service delivery issues are identified through data analysis, the DiC Manager works with *New Friends* DiC staff and peer outreach workers to implement changes. DiC routine program data are also aggregated on a monthly basis and displayed on whiteboards within the DiC for clients and peer staff to see monthly performance. These monthly data reports are also sent to the PSI/Lao HQ where the Director reviews the aggregated reports for all DiCs. The PSI/Lao Research Team reviews and cleans aggregated data and does follow-up data quality checks with individual *New Friends* DiCs if data do not look correct. The Research Team also aggregates data on a semi-annual and annual basis for analysis of trends and for reporting to donors. PSI/Lao reports results to USAID/RDMA annually.

An innovation that PSI/Lao has employed in their MIS system is the use of a Unique Identifier Code (UIC) which is allocated to each individual who attends a DiC. The use of an UIC is an anonymous way for program staff to measure the number of individuals reached, rather than simply just the total number of DiC visits. The UIC can also be used to track the uptake of DiC services by individual clients, record patterns of attendance and can reveal whether or not the client is reached regularly.

As a Global Fund recipient, PSI/Lao periodically sends routine M&E program data to the Ministry of Health. Lao does not have a national M&E framework for HIV and AIDS and nor is there a functional national M&E Technical Working Group.

Research

PSI/Lao has strong internal technical capacity for strategic information. Through analysis of survey data, PSI/Lao has established behavioral determinants for programming.

PSI/Lao conducted a baseline TRaC survey for FSW in 2005 and then conducted a follow-up TRaC survey in 2008. PSI/Lao conducted a baseline TRaC survey for MSM in 2004 and then conducted a follow-up TRaC survey in 2006. PSI/Lao is now moving into second generation surveillance with the planned 2010 TRaC survey for MSM that will be conducted in collaboration with MoH/CHAS. This will include biomarkers for HIV and STI. PSI/Lao also conducts TRaC surveys for malaria.

Regular implementation of TRaC surveys has allowed for assessment of intervention outcomes over time with respect to how behaviors, attitudes, knowledge, and beliefs have changed in target populations. The TRaC surveys are used to monitor behaviors and determinants of behavior and evaluate behavioral outcomes of the target MARP populations. This allows close monitoring of the MSM and FSW populations to establish behavioral determinants for program design and implementation. For example, the behavioral determinants that are identified from various track surveys are used as the basis of the creation of a Health Impact Plan, which is the strategic plan that describes how a prevention intervention project will be delivered. Additionally, these identified behavioral determinants are also used for the development of client “archetype” for each target population for use in program design and implementation.

Behavioral determinants identified through the TRaC surveys are translated into key messages and IEC materials. New messages and IEC materials are tested and packaged for delivery through the appropriate channels. For example, between 2004 and 2006, there were significant increases in the following behaviors: condom use at last anal sex with casual partners, condom use at last sex with boyfriends and use of water-based lubricant during anal sex ²⁴. PSI/Lao responded by refocusing BCC communications specifically on the topic of improving consistent condom use and proper use of lubricant during anal sex with all types of partners as well as efforts made to improve knowledge and correct misconceptions about HIV and AIDS, STIs, and condom use, and lubricant use among TG.

PSI/Lao's research work assesses the extent of outcomes from interventions and uses this evidence-base to tailor prevention intervention strategies. TRaC data are regularly disseminated internally to all departments at PSI/Lao HQ, however, there is limited sharing of TRaC data with external partners.

Another research innovation is the way PSI/Lao is measuring the performance of their Malaria Eradication Project by monitoring health outcomes at the village level. Disease monitoring is done externally by trained MoH doctors who do random blood draws using lot quality assurance sampling (LQAS). Project performance is measured by the degree to which the prevalence of malarial disease has changed since the previous year. PSI/Lao is on the cutting-edge by measuring "health impact". PSI would like to monitor the health impact of its HIV programs in a similar way. With the addition of biomarkers for HIV and STI in the next round of the MSM TRaC survey, PSI/Lao will get closer to this goal of measurement of health impact.

Special studies

PSI/Lao will continue to develop its second generation surveillance work by conducting a pilot survey in 2010 to track Gonorrhea and Chlamydia rates among FSW.

Project MAP

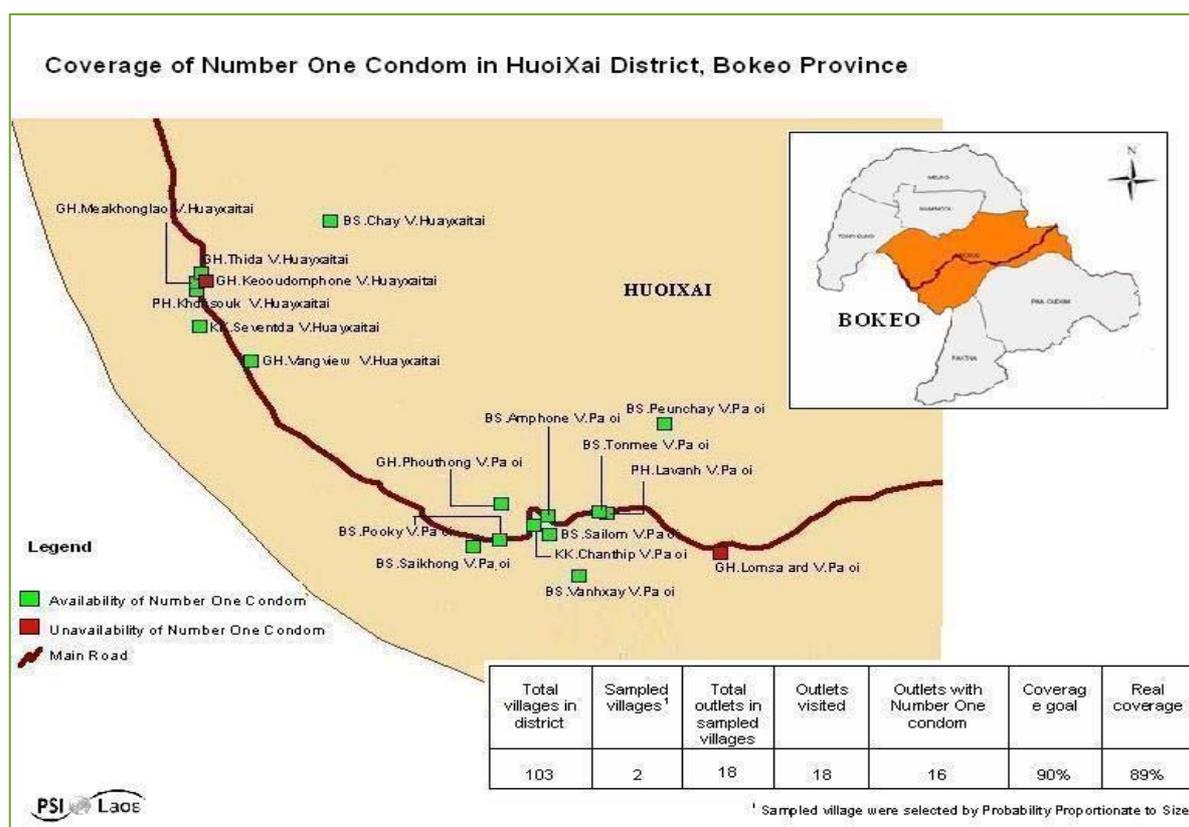
PSI/Lao regularly conducts Project MAP (Measuring Access and Performance) surveys to track the availability of prevention products such as condoms and lubricant in all MSM and FSW project sites. Project MAP is the main tool that PSI/Lao uses to ensure MARP access to HIV prevention products when and where they are needed. Project MAP uses GPS satellite technology and the WHO's Health Mapper software to track product availability in hot spots.

The 2009 Project Map study found on an overall basis that PSI Number 1 condoms were available in 76% of traditional and non-traditional outlets, demonstrating high market penetration. In Vientiane Capital, 80% of outlets within 1,500 meters of a MSM and FSW hotspot (bar/nightclub, hotel, guesthouse) stocked Number 1 condoms, ²⁵ An illustrative example of the application of Project Map in Bokeo Province is shown in Figure 6.

²⁴ PSI/Lao Research Brief — HIV Prevention Programming among Transgenders: Lessons from Lao (December 2008)

²⁵ PSI/Lao 2009 Project MAP Report (Early Draft)

Figure 6 ²⁶: Project MAP and GPS



5.4.3 Strengths and facilitating factors

Leadership

The Country Director places high priority on using strategic information to guide program development and implementation. This belief that strategic information is necessary, critical, and useful to implement their programs and demonstrate their performance is to be commended.

Turning research into action

PSI/Lao is a national leader in data/strategic information use. PSI/Lao routinely turns both program monitoring data and research into action linked directly to improving their programming, thus making their programs more evidence-based.

Applying private sector approaches/models to international public health

PSI/Lao employs many private sector approaches/models in their international public health work. These business practices as well as some broader conceptual approaches, (i.e. social marketing, “total market approach”, DALY measurement of performance), impose a rigor that allows alternate ways to measure performance of their programs.

5.4.4 Challenges and barriers

Analysis of strategic information is not always directly tied to advocacy

PSI/Lao collects a tremendous amount of data from their strategic information and research activities. While it is commendable that this information is used for improving PSI programs,

²⁶ PSI/Lao – USAID EoP Evaluation Presentation (11 Jan 2009)

findings are not translated into advocacy with external partners to guide policy and programming by others at the national and sub-national levels.

Dissemination of PSI/Lao strategic information and research needs strengthening

PSI/Lao does a good job of disseminating results from monitoring and evaluation and research internally; however, sharing and disseminating strategic information externally is limited.

Involvement of community members in evidence-based decision making

There is a need to strengthen government-community partnerships in Lao so that community members may participate in the analysis and synthesis of strategic information to make decisions about HIV programming and policies at levels higher than program implementation. To facilitate community involvement in planning and decision-making, those infected and affected by HIV need to have an educated voice in determining the scope, depth, and content of HIV prevention programming. In order to do this, the capacity of community members to understand strategic information and how it can be used is critical.

5.4.5 Replication and sustainability

PSI/Lao's strategic information and research portfolio has a good potential for replication. These routine M&E/SI and research activities are the foundation of any strong international public health intervention program as the activities are directly linked back to program implementation and results are used for decision-making and program improvement at the project level. The only activity that may be harder to replicate more widely is the use of HIV and STIs biomarkers within the TRaC survey for MSM and FSW. This is an innovative new activity to try and measure disease burden as well as behavior within the same population and PSI/Lao will only be piloting this in 2010. Close monitoring of this activity will be needed in order to ascertain feasibility for replication.

The foundation of integrating SI and research with programs is critical and is a model that is sustainable in any disease/public health area. All programs should endeavor to reach this level of integration.

5.5 Program Management

5.5.1 Key achievements

Management

PSI/Lao has developed strong internal management systems with good feedback loops. This ensures that progress and any problems or issues are closely monitored by the management team, with a focus on resolution.

Leverage of funds

PSI/Lao has a strong orientation to leveraging additional funds from a range of donors to scale-up its HIV work and to expand into other public health areas. PSI/Lao is receiving approximately 17% of all Global Fund monies for HIV and malaria programming in Lao. In addition to enhanced funding flows to PSI, PSI has provided broader support for the development of proposals, resulting in additional funding for other partners. PSI is an active member of the Lao CCM.

Private sector capacity building

PSI has conducted capacity building for private sector pharmacists to improve their dispensing practices for STI pharmaceuticals, particularly for PSI's branded STI kits. Mystery client surveys are also used to monitor the quality of dispensing. PSI capacity building of the private sector in relation to condom social marketing has also been a significant achievement.

Condom social marketing

PSI/Lao estimates it currently has around 58% of the national condom market. PSI's CSM work in Lao has significantly increased the size of the total condom market (i.e. the number of people who buy condoms) and made condoms and lubricant available at an affordable price to the people of Lao. PSI/Lao has a strong focus on operating in a way that encourages new private sector entrants into the condom market. In earlier years, PSI sold condoms at a very low price of less than US \$0.10 per pack. This was necessary to build the market as condoms had not previously been marketed or used in much of Lao. PSI reports that the condom market has changed in recent years, with many people, including MARPs, being prepared to buy quality condoms at higher prices. This has allowed PSI to increase the price for some PSI condoms. The reasons for the increased prices is primarily to ensure that low-priced socially marketed condoms do not prevent new private sector commercial condom brands from entering the market. A secondary benefit is to generate additional income that can be channeled back into the CSM program. Importantly, PSI has maintained a low price for on its 'base brand' condom (Number 1 Deluxe) to ensure access for the most poor and vulnerable. In the interests of sustainability it is encouraging to see that non-PSI private sector condoms are starting to enter the Lao market at all price levels.

PSI is currently in the process of contracting out national distribution of condoms to a private sector specialist. This function, which is currently done in-house, will allow PSI's sales team to concentrate on development of non-traditional sales outlets.

In FY 09 PSI/Lao collected approximately US \$45,000 in income from condom social marketing. This money is primarily used to procure more products and to support distribution costs for CSM.

PSI holds annual workshops in priority provinces (around half of Lao's 15 provinces) with Provincial Coordinating Committees for AIDS (PCCA), other government agencies such as police, and a broad range of social franchising outlets, including pharmacies, entertainment establishments and other types of non-traditional outlets. On occasion the provincial Governor has attended some of these workshops. The purpose of the workshops is to review progress and conduct advocacy for the private sector to be allowed to continue with social marketing of condoms. This is especially important in provincial Lao where social attitudes can be conservative. There has been some disagreement between PSI and MoH/CHAS on the best approach to advocacy on condoms with provincial government officials. This points to the need for improved communication and coordination between PSI and MoH/CHAS.

MoH/CHAS has requested technical assistance from PSI/Lao on quality assurance systems for condoms.

5.5.2 Strengths and facilitating factors

Incentives

PSI's Lao program is highly innovative, especially in the area of incentives. Incentives for peer educators have resulted in a higher than expected increase in HIV testing among MSM/TG. PSI is considering whether it would be feasible to introduce incentives for peer educators, based on

population health indicators. For example, basing incentives on a reduction in STI prevalence among MSM/TG in a defined geographic area. A similar approach has been taken at the village level with PSI's malaria program where PSI staff are rewarded for reductions in the prevalence of malaria.

Technical assistance models

PSI/Lao takes a broad approach to capacity building and technical assistance, with a strong emphasis on on-the-job mentoring, learning by doing, and self-directed learning, with a lesser emphasis on training.

Relations with other USAID implementing agencies

In Vientiane, PSI is responsible for HIV prevention programs for TG and feminized MSM, and Burnet, under a sub-grant from Pact, is responsible for programs targeting MSM with a masculine or normative identity. This segmentation of the target group appears to be working effectively and there are good and cooperative relations between PSI and Burnet. However, in Luang Prabang, where Burnet is not working, PSI appears to be reaching a broad range of MSM.

Similarly, for FSW, FHI/Lao is responsible for programs targeting FSW in drink shops and PSI/Lao for FSW in karaoke, nightclubs, hotels and guest houses. This delineation appears to be working well, although there appears to be a low amount of cross-fertilization between the two projects. Reports and interviews confirm that there are some strained relations between PSI/Lao and FHI/Lao. This may in part be attributable differences in organizational cultures to how the agencies interact with the government at the national and sub-national levels. PSI's orientation is more towards working with other partners through the Global Fund CCM, rather than with CAs. As FHI is not on the CCM, this hinders collaboration. However, there is a fresh opportunity to forge new working relationships between PSI and FHI.

5.5.3 Challenges and barriers

Relations with the Lao Government

The Global Fund principal recipient in Lao is in a separate section of the Ministry of Health than CHAS. This arrangement has resulted in some tension between CHAS and the PR. As a recipient of Global Fund monies, PSI has invested significantly in its relationship with the PR office, but less so with CHAS. While MoH/CHAS reports that relations with PSI have improved and are generally good, MoH/CHAS is of the view that there is room for further improvement through more regular communication and a clear understanding of PSI's annual work plan. The lack of a USAID presence in Lao may also have contributed to less than optimal communication between MoH/CHAS and PSI. An annual meeting between MoH/CHAS, USAID and USAID funded cooperative agencies (CA) to outline annual work plans and budgets would facilitate improved relations. This could be followed up by quarterly meetings between MoH/CHAS and all CAs or individual CAs.

In Luang Prabang, the only province visited by the Assessment Team, the Provincial Coordinating Committee for AIDS (PCCA) reported good relations with PSI. The Provincial Health Department Director suggested convening regular biannual meetings with PSI to review lessons learned.

Incentives

PSI needs to be mindful of possible unintended distortions resulting from incentives. In other countries there is evidence of incentive payments resulting in health workers targeting lower risk

individuals to meet targets, meaning those most in need of services are not reached. Incentives need to be designed in such a way as to avoid this possibility.

The payment of incentives to peer educators based on the numbers of persons who come for VCT has resulted in a significantly greater number of MSM/TG presenting for VCT. There is the possibility that peer educators may be sharing the incentive with clients to encourage them to have VCT. Incentives need to be kept at low rates to minimize this possibility. PSI is also providing at least some MSM/TG with t-shirts and caps for having VCT. As these products have a monetary value, this could be regarded as paying for HIV testing, which raises ethical concerns, especially with clients who are poor.

Quality assurance for VCT and STI clinical work

Quality assurance systems in place for PSI's STI and VCT clinical work include:

- A PSI developed HIV and STI testing algorithm.
- Trainings and refresher trainings by the MoH.
- Periodic government oversight of VCT clinical work.
- Ad hoc (infrequent) VCT site evaluations using experts from PSI's US headquarters.
- All HIV positive test results and 10% of negative test results are sent to the MoH for test kit quality assurance purposes.
- Use of PSI's internal monthly and quarterly reporting to identify and solve issues.
- FHI's regional Technical Advisor for Sexual and Reproductive Health has ad hoc input to PSI/Lao, in response to requests. His inputs are highly valued by PSI. These take the form of telephone calls and infrequent in-country meetings. FHI's Technical Advisor has not been involved in training for PSI clinical staff or ongoing assessment of clinical service provision.

It was not possible for the Assessment Team to evaluate the quality of training or MoH periodic oversight of VCT.

Similarly, it was not possible for the Assessment Team to evaluate the quality of PSI's STI clinical work. There are, however, significant concerns with the adequacy of PSI/Lao's STI quality assurance systems that relate to the absence of periodic on-site oversight of the STI clinics. Good quality STI services require a combination of effective training, with an emphasis on both clinical and social aspects of STIs in MSM and FSW, plus expert supervision of clinical practice. Even with good training, there is no guarantee that clinicians will provide quality services as there is a high likelihood of reverting to former poor practices. Ongoing regular supervision should involve quarterly visits by an STI expert to all clinics to observe clinical practice and provide feedback. This should be accompanied by clinical record audits and inspections of clinics to check for things such as the expiry date of drugs and test kits and the availability and use of essential equipment. The Assessment Team does not have any information on the quality of STI training in Lao. At present there is no system for regular supervision of STI clinical work. This issue needs to be addressed by PSI. FHI has indicated that it does not have the capacity to provide regular monitoring of PSI's STI work at the clinic level. It is not known whether sufficient technical expertise exists within Lao and would be available to undertake this function. If external technical assistance is needed it should have a strong orientation towards building the capacity of local experts so this function can in time be carried out by nationals.

PSI Lao has identified the following priorities for STI technical assistance, in priority order:

1. STI prevention and treatment among MSM (highest priority) and FSW (lower priority).

2. Treatment protocols (clinical and syndromic) for staff at DiCs/clinics.
3. Drug resistance issues.
4. How to measure health impact.

Community mobilization

PSI Lao has indicated that it would prefer to work on a sub-grant model with CBOs for implementation of HIV/STI programs, rather than these programs being directly implemented by PSI. Given government restrictions on the development of civil society in Lao, this approach is currently not possible. However, by developing the capacity of MARPs to implement programs, capacity for sustainable programs is being developed, with the exception of organizational development.

5.5.4 Replication and sustainability

Apart from the PSI Lao Country Director who is also the Chief of Party for the cooperative agreement, other management positions are filled by Lao nationals. PSI capacity building of these nationals has contributed to the sustainability of this program. Similarly, capacity building of peer educators will result in ongoing capacity beyond the life of the programs.

PSI capacity building in the area of strategic information has been largely internally focused on PSI staff. These staff have built up considerable technical expertise. PSI could play a useful role in capacity building of other partners. PSI's joint surveillance work with MoH/CHAS, however, is a good example of working with other partners on strategic information in a way that may produce sustainable results.

As noted above, PSI's condom social marketing has been undertaken in a way that encourages private sector entrants into the condom market, which will assist with long term sustainability.

6. Thailand

6.1 Overview of HIV in Thailand

During the 1990s, Thailand was a global leader in HIV prevention and through programs and policies like the “100% Condom Program” were able to reduce HIV prevalence significantly among FSW and the general population. These efforts were not sustained, and by 2000 prevention programs received just 8% of the national HIV budget—significantly less than during the previous decade²⁷. Among FSW, some of the behavior change achieved in the 1990s began to erode, with declining rates of condom use, rising rates of STI transmission and a move from brothels to street-based or freelance work which were not reached by prevention efforts. Additionally, the prevention needs of MSM were largely ignored. In Bangkok, HIV prevalence among MSM rose from 17% to 31% between 2003 and 2009. With the approval of Global Fund Round 8, FSW, IDU, MSM and migrants are target groups for targeted HIV prevention activities.

6.2 Overview of PSI/Thailand program

USAID’S agreement with PSI (2007–2010) originally included activities for Thailand. However, due to unexpected budget cuts to USAID’S Thailand HIV program, financial support for the PSI/Thailand program ended in FY08, shortly after this agreement with PSI began, resulting in the closure of PSI/Thailand’S office. Therefore, the original activities outlined for PSI/Thailand in the proposal were not formally evaluated during this end of project review.

Prior to FY08, PSI/Thailand implemented a HIV prevention program for IDU with DiCs in Bangkok, Chiang Mai, and Chiang Rai (‘Ozone’ project) and a HIV prevention program for the transgender population in Pattaya (‘Sisters’ project). The IDU activities ended in FY08, but limited support continued to PSI/Sisters for capacity building and technical training through USAID agreements with Pact and FHI. In FY09, PSI successfully leveraged Global Fund resources and became the Principal Recipient for IDU activities under the Thailand Global Fund Round 8 grant. PSI has now reopened their office in Thailand and is supporting IDU activities through the Ozone project which were originally started with USAID support. PSI is also the sub sub–recipient for MSM activities (with support to Sisters for transgender activities) under Global Fund Round 8 grant.

USAID/RDMA’S programmatic priorities in Thailand involve providing technical assistance and capacity building to USG partners implementing HIV programs for MSM including male sex workers (MSW) and TG in Bangkok, Chiang Mai and Pattaya. The Assessment Team met with the new PSI/Thailand Country Director and visited the PSI/Sisters project.

6.3 Prevention

6.3.1 Outline of Thailand prevention program

The PSI/Sisters project promotes HIV prevention and overall sexual health for Pattaya’S transgender population. The PSI/Sisters project focuses on ‘sustaining long–term behavior change among transgenders through a peer–driven behavior change communication program in geographic hotspots’. The behavior change communication strategy delivers knowledge on HIV prevention through outreach to bars and other entertainment establishments, home outreach, and

²⁷ UNDP, 2004. Thailand’S Response to HIV/AIDS.

a drop-in center that provides individual counseling, HIV and STI prevention information, VCT, skills building, and referrals to sexual health services. The Sisters Drop-in Center serves as a safe social and recreational space for transgenders.

6.3.2 Key achievements

Development of best practice models on HIV/STI prevention – Sisters DiC

Sisters DiC provides a 'safe place' for the transgender population (TG). The center's mission is to change the attitudes and behaviors of transgenders who are at risk for HIV and other STIs by providing information together with the distribution of condoms and lubricants.

The main services of the Sisters DiC include center based activities and peer education/outreach. They provide on site health services, one-to-one counseling, as well as social activities such as make-up, sports and cooking. Referrals can be made to transgender-friendly providers of medical services. One of Sisters goals is to foster public support and greater acceptance of the transgender community in Pattaya. This remains a challenge. Currently, Sisters DiC has over 700 members.

Establishment of 'in-house' counseling and VCT services since 2006

In collaboration with the Department of Health Promotion, Banglamung Hospital, Pattaya, Sisters DiC began providing counseling and VCT services in 2006. A TG nurse from Banglamung Hospital comes to the drop-in center for four sessions per week to provide VCT. PSI should be applauded for the successful partnership with the hospital. Sisters DiC is also one of the sites selected for the community-based VCT rapid testing pilot project under the Global Fund Round 8 grant.

Significant success in reaching hard to reach populations – TG sex workers

Peer educators, working through the Sisters DiC, are successful in reaching TG sex workers at three types of locations; at targeted bars/hotspots, during home visits to TG, and at the Sisters DiC. Sisters recognizes that while successful in reaching TG, the behavior change process requires a long-term commitment, with frequent visits and 'after-service' contact.

Sisters PE indicated that while the situation has improved, there still remains occasional interference with their work from law enforcement authorities. However, government health authorities recognize the value of the Sisters PE HIV awareness and prevention efforts.

PSI/Sisters involves MARPs in developing behavior change strategies, messages and materials

PSI/Sisters place emphasis on including TG in the design and delivery of BCC interventions and resources. TG peer educators are skilled in leading prevention activities among beneficiaries. Sisters involvement of TG in PE activities helps to ensure TG access to VCT services.

PSI/Sisters has contributed to improved access and availability of HIV/STI preventive products (condoms, lube) for MARPs to these preventive products

Distribution of branded condoms and lubricants are an essential part of Sisters peer education and outreach activities. This includes demonstrations/training in correct condom use.

6.3.3 Strengths and facilitating factors

Strengths and facilitating factors include:

- A dedicated and skilled group of peer educators working both in outreach and drop-in center activities.
- A strong, supportive relationship with government health services (Banglamung Hospital, Pattaya) allowing for MARP-friendly clinical services at the drop-in center.
- Involvement of TG in the development of IEC interventions and resources.

6.3.4 Challenges and barriers

- Condom use by IDU and FSW with regular partners is very low (although there is no issue with availability of quality condoms).
- TG are reluctant to approach their regular partners about condom use. Attitude change will require a significant and sustained IPC approach.
- Stigma and discrimination towards TG is still considerable. Addressing this will require the creative and sustained efforts focusing on the 'general population' and law enforcement authorities.
- Maintaining contact with migrant TG (Thai, Vietnamese, Khmer and Lao) is an issue. Innovative approaches and resources to maintain meaningful, influential contact with migrant TG need to be considered.
- Behavior change is a long-term process. Sisters PE must spend considerable time in carrying out outreach activities to ensure solid change.
- Although TG have unique needs and concerns (such as hormonal issues), TG are often grouped with broader MSM programming which may not address TG specific issues. There is a need to develop TG specific BCC resources and approaches to respond to their distinct and unique needs.
- Due to budget constraints, PSI/Sisters has been unable to implement the TRaC methodology for the TG program. In order to measure effectiveness of the current interventions, adjust program needs, and contribute to the documentation and replication of the model, it is important that the USG or other funds be found to implement TRaC.

6.3.5 Replication and sustainability

The Sisters DiC is strong, both from a management and programmatic sense. The center is well organized, has strong and supportive linkages with government partners and has an active in-house activity and outreach program for the TG community in Pattaya. Sisters are acknowledged as being innovative and successful in reaching out to and organizing the TG community in Pattaya, including both Thai and non-Thai TG. This model should be fully documented and considered for replication in other areas of Thailand and regionally.

Procurement Sensitive

7. **Future Directions (THIS SECTION HAS BEEN REMOVED PER ROP)**

PSI interventions in Burma, China, Lao and Thailand display a high level of performance, with strong progress to date. The progress is even more impressive given the political and social constraints faced in these countries. The rate of progress for interventions contributing to HIV and AIDS prevention is impressive. Nevertheless, a number of challenges remain which must be taken into consideration when planning for further USAID inputs to Burma, China, Lao and Thailand.

This section puts forward recommendations for future directions by USAID organized by 1) prevention, 2) strategic information and 3) program management per country as well as suggesting regional needs.

Annex 1: Key documents reviewed

PSI Burma

1. Social Marketing for STI/HIV Prevention Among High-Risk Groups in Burma, Implementation Plan, Year 1 (1 October 2007–30 September 2008), November 2007
2. Social Marketing for STI/HIV Prevention Among High-Risk Groups in Burma, Implementation Plan, Year 2 (1 October 2008–30 September 2009), July 2008
3. Social Marketing for STI/HIV Prevention Among High-Risk Groups in Burma, Implementation Plans for PSI/China, PSI/Laos/ & PSI/Burma (combined), Year 3 (1 October 2009–30 September 2010), July 2009
4. Population Services International: Burma — Annual Report FY2007
5. Population Services International: Burma — Annual Report FY2008
6. Population Services International: Burma — Annual Report FY2009
7. Social Marketing for STI/HIV Prevention Among High-Risk Groups in Burma, China, Laos, and Thailand – Proposal for Cost Extension (1 October 2007–30 September 2010), revised July 2007
8. National AIDS Program – National Strategic Plan for HIV and AIDS in Myanmar Progress Report 2008
9. National AIDS Program, Department of Health, Ministry of Health – Report of the HIV Sentinel Sero-Surveillance Survey Myanmar 2008
10. Myanmar (2008): HIV/AIDS TRaC Among Female Sex Workers; First Round
11. Myanmar (2008): HIV/AIDS TRaC Among Clients of Female Sex Workers; First Round
12. Myanmar (August 2009): MAP – Measuring Access and Performance Study Round 2 – Coverage and quality of male condoms in Myanmar
13. Myanmar (2008): HIV/AIDS TRaC Among Men Who Have Sex with Men; First Round

PSI China

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3. PSI/China Huxianghao Program (PSI fact sheet)
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9. PSI/Laos: Research Brief (2008) – HIV Prevention Programming among Transgenders: Lessons from Laos
10. Laos (2009): First Round HIV/STI Prevalence and Third Round TRaC Survey Among Male-to-Female Transgenders in Vientiane Capital and Savannakhet, Lao PRD (TRaC Study Design proposal submitted to CHAS 15 October 2009)
11. UN Draft Document: Health Financing Strategy 01-05-2010
12. Draft Report: External Review of the 100% Condom Use Programme and Sexually Transmitted Infection Services in Selected Sites in Lao People's Democratic Republic (June 2009)

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Annex 2: Site visits/organizations visited

Burma

Organization	Location
PSI Senior Management, PSI Burma Headquarters	Rangoon
PSI TOP Program Management	Rangoon
PSI TB Program Management	Rangoon
International HIV/AIDS Alliance and partners	Rangoon & Mandalay
National AIDS Program, Ministry of Health	Rangoon
PSI TOP Program FSW and MSM outreach sites	Rangoon
Pact staff	Rangoon
UNAIDS/Myanmar	Rangoon
PSI TOP Drop-in Center	Lashio
Asian Harm Reduction Network Drop-in Center	Lashio
PSI Drop-in Center	Mandalay
PSI QC Center	Mandalay
Local Department of Health	Mandalay

China

Organization	Location
Guangxi Prevention and Treatment of HIV/AIDS Committee Office	Nanning
Nanning Narcotics Control Committee Office	Nanning
Wangzhou Community Detoxification and Rehabilitation Center/Management	Nanning
Hengyang MMT Clinic	Nanning
Medecins sans Frontieres	Nanning
Luzhai CDC	Luzhai
Red Ribbon Center	Luzhai
Shangyi Community Center	Kunming
PSI staff/PSI office	Kunming
Yunnan Institute for Drug Abuse	Kunming
Huxianghao Ba Drop-in Center (MMT provision)	Kunming
PSI staff/PSI office	Kunming
Huxianghao Ba Drop-in Center (Peer Educators)	Kunming
Huxianghao Ba Drop-in Center (Beneficiaries)	Kunming
Mile Public Health Bureau, AIDS Office	Mile
Honghe Brothers Center	Mile
Sisterhood Health Home (MCH doctor)	Mengzi
Mengzi CDC	Mengzi
Mengzi County Public Health Bureau, AIDS Office	Mengzi
Sisterhood Health Home (Beneficiaries)	Mengzi
Sisterhood Health Home (Peer Educators)	Mengzi

Organization	Location
Honghe Prefecture CDC	Mengzi
Kangxin Home	Mengzi
Green Garden Community Center	Gejiu

Lao

Organization	Location
PSI managers and staff, PSI Headquarters	Vientiane
FHI FSW DiC	Vientiane
FHI managers and staff	Vientiane
Burnet Institute	Vientiane
Ministry of Health/Centre for HIV, AIDS and STIs	Vientiane
WHO	Vientiane
UNAIDS	Vientiane
PSI New Friends DiC	Vientiane
Retail pharmacies	Vientiane
Guest houses	Vientiane
PSI New Friends DiC	Luang Prabang
Provincial Coordinating Committee for AIDS	Luang Prabang

Thailand

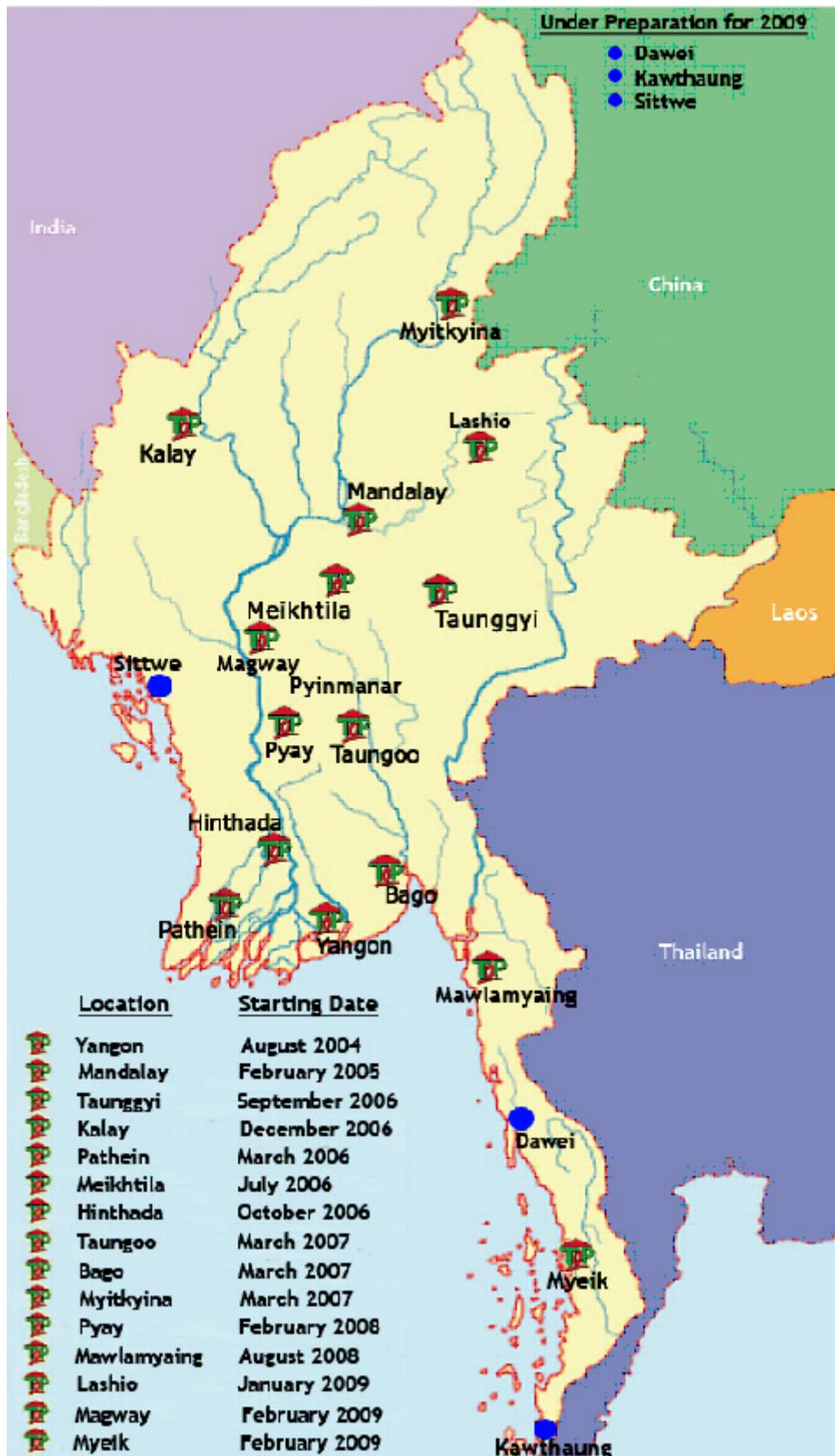
Organization	Location
SWING	Pattaya
Sisters	Pattaya

USAID/RDMA regional partners

Organization	Location
Health Policy Initiative	Bangkok (via phone)
Family Health International Asia Pacific Regional Office (FHI/APRO)	Bangkok; China (via phone)
Pact	Bangkok

Annex 3: Map of current locations of the TOP program (Burma)

Targeted Outreach Program (2004 - 2010) PSI/Myanmar



Annex 4: PSI/Burma TOP activity data

This Annex provides more detailed data in relation to PSI/Burma's Targeted Outreach Program. An overview of this data is provided in 3.3.2 in the main section of the report.

TOP outreach activity levels: MSM ²⁸

Table 6: TOP MSM outreach contacts: 2007–2009

Year	New individual MSM contacted	% increase previous year	Repeat MSM contacts*	% increase previous year	Total MSM contacts#	% increase previous year
2007	38,629	–	61,488	–	100,117	25
2008	47,562	23	77,353	26	124,915	25
2009	46,187	– 3	101,248	31	147,435	18
Total	132,378		240,089		372,467	

* Repeat MSM contacts is the total number of outreach contacts with previously reached MSM. It is not individual MSM and includes repeat contacts with the same MSM. # Total MSM contacts is the total of new individual contacts, plus repeat MSM contacts. Source: PSI Burma.

TOP outreach activity levels: FSW

Table 7: TOP FSW outreach contacts: 2007–2009

Year	New individual FSW contacted	% increase previous year	Repeat FSW contacts*	% increase previous year	Total FSW contacts*	% increase previous year
2007	33,239	–	56,229	–	89,468	33
2008	30,065	– 10	67,231	20	97,296	9
2009	33,884	13	96,442	43	130,306	34
Total	97,188		219,902		317,070	

* Repeat FSW contacts is the total number of outreach contacts with previously reached FSW. It is not individual FSW and includes repeat contacts with the same FSW. # Total FSW contacts is the total of new individual contacts, plus repeat FSW contacts. Source: PSI Burma.

TOP DiC activity levels: MSM

Table 8: TOP MSM DiC visits: 2007–2009

Year	New individual MSM DiC members	% increase previous year	Total individual MSM DiC visits	% increase previous year	Total MSM DiC visits*	% increase previous year	Average No. DiC visits/MSM member#
2007	7,038	–	10,201	–	54,015	–	5.3
2008	9,013	28	13,555	33	63,137	17	4.7
2009	13,045	45	19,621	45	98,137	56	5.0
Total	29,096		43,377		215,289		

* Total visits; not individuals. # This data shows the average number of DiC visits per year for members who visited in that year but does include MSM members who registered in a previous year but did not visit in that year. Source: PSI Burma.

²⁸ Activity data is for the calendar years 2007–2009. USAID funding of PSI's activities under the existing contract extension commenced in October 2007. Accordingly, the 2007 data can primarily be regarded as baseline data for this contract.

TOP DiC activity levels: FSW

Table 9: TOP FSW DiC visits: 2007–2009

Year	New individual FSW DiC members	% increase previous year	Total individual FSW DiC visits	% increase previous year	Total FSW DiC visits*	% increase previous year	Average No. DiC visits/FSW member#
2007	5,938	–	8,504	–	48,070	–	5.7
2008	6,749	14	10,302	21	49,303	3	4.8
2009	9,874	32	15,936	54	81,414	65	5.1
Total	22,561		34,742		178,787		

* Total visits; not individuals. # This data shows the average number of DiC visits per year for members who visited in that year but does include FSW members who registered in a previous year but did not visit in that year. Source: PSI Burma.

STI clinical services: MSM

Table 10: STI consultations and treatment at TOP DiCs for MSM: 2007–2009

Year	STI consultation and Treatment	% increase on previous year	% of individual MSM attending DiCs who went to STI clinic
2007	3,972	–	39
2008	6,145	55	45
2009	8,749	42	45
Total	18,866		

Source: PSI Burma

STI clinical services: FSW

Table 11: STI consultations and treatment at TOP DiCs for FSW: 2007–2009

Year	STI consultation and Treatment	% increase on previous year	% of individual FSW attending DiCs who went to STI clinic
2007	4,948	–	58
2008	6,204	25	60
2009	9,153	48	57
Total	20,305		

Source: PSI Burma

VCT services: MSM

Table 12: VCT at TOP DiCs for MSM: 2007–2009

Year	MSM having VCT	% increase on previous year	% with HIV + results	% of individual MSM attending DiCs who had VCT
2007	1,520	–	16	15
2008	2,342	54	17	17
2009	2,514	7	11	13
Total	6,376			

Source: PSI Burma

VCT services: FSW

Table 13: VCT at TOP DiCs for FSW: 2007–2009

Year	FSW having VCT	% increase on previous year	% with HIV + results	% of individual FSW attending DiCs who had VCT
2007	2,022	–	19	24
2008	2,212	9	18	21
2009	2,664	20	17	17
Total	6,898			

Source: PSI Burma

Annex 5: Strategic information activities for PSI/Burma and PSI Lao

PSI/Burma

The following strategic information activities were included in PSI/Burma's annual work plans for the period 2007-2010. Section 3.4 contains an analysis of these activities.

Year 1: 2007-08

- Conduct annual TRaC survey (FSW, clients of FSW, and MSM) in Rangoon, Mandalay, Lashio, Myitkyina, and additional intervention area(s) as appropriate
- Conduct Project MAP (Measuring Access and Performance) survey to track product availability in all project sites
- MIS (monthly monitoring report)

Year 2: 2008-09

- Conduct annual TRaC survey (FSW, clients of FSW, and MSM) in Rangoon, Mandalay, Lashio, Myitkyina, and additional intervention area(s) as appropriate
- Conduct Project MAP (Measuring Access and Performance) survey to track product availability in all project sites
- MIS (monthly monitoring report)

Year 3: 2009-10

- Conduct annual TRaC-M survey (3 surveys in 2009 focused on FSW, clients of FSW, and MSM)
- Conduct Project MAP (Measuring Access and Performance) survey to track product availability in all project sites for MSM and FSW
- MIS (monthly monitoring report)
- Qualitative survey on determinants on behavior for IDU (funded by BMGF)
- Feasibility assessment on social marketing of clean needles and syringes

PSI/Lao

The following strategic information activities were included in PSI/Lao's annual work plans for the period 2007-2010. Section 5.4 contains an analysis of these activities.

Year 1:

- Conduct follow-up TRaC survey for MSM in Vientiane, Savannakhet, and Luang Prabang
- Conduct Project MAP (Measuring Access and Performance) survey to track condom availability in all four target sites
- Analyze data from surveys
- Disseminate survey results to relevant national and local governmental organizations, NGOs, and international partners
- Train partners and other organizations to read and understand survey information

Year 2:

- Conduct follow-up TRaC survey for MSM in Vientiane, Savannakhet, and Luang Prabang
- Conduct Project MAP (Measuring Access and Performance) survey to track condom availability in all four target sites
- Analyze data from surveys

- Disseminate survey results to relevant national and local governmental organizations, NGOs, and international partners
- Train partners and other organizations to read and understand survey information

Year 3:

- Conduct follow-up TRaC survey for FSW in Vientiane, Savannakhet, Champasak, and Luang Prabang
- Conduct follow-up TRaC survey for MSM in Vientiane, Savannakhet, and Luang Prabang
- Conduct Project MAP (Measuring Access and Performance) survey to track condom availability in all four target sites
- Analyze data from surveys
- Disseminate survey results to relevant national and local governmental organizations, NGOs, and international partners
- Train partners and other organizations to read and understand survey information

Annex 6: PSI results by PEPFAR core indicators and project objectives

This annex presents data provided by PSI through the USAID PEPFAR annual reporting requirement in FY07–09. PSI is required to report annually to USAID using the PEPFAR “core indicators”, listed below in italics. The “Project Objectives” are those that were listed in PSI’s Mekong Regional Cost Extension Proposal and contribute to USAIDR/RDMA’s HIV and AIDS strategy. The first year of PSI’s Mekong Regional Cost Extension Proposal was FY08 (October 1, 2007). FY07 data under the previous PSI agreement is also provided to serve as a baseline. FY10 data will be available upon completion of this project in October 2010. Below is a list of limitations regarding the data presented below:

- All targets and results below are highly variable as the PEPFAR definitions of target setting and indicators changed from year to year. This makes it difficult to compare the results over the years; however progress has been achieved over the life of the project as has been described in each of the country chapters in the report.
- Useful quantitative information is not available for the project objectives of: increased access to strategic information and strengthened the enabling environment. This is because the PEPFAR indicator in this area includes only number of people of trained, which does not accurately capture meaningful progress toward this project objective. Qualitative progress made by PSI toward these important two objectives has been described in each of the country chapters in the report.
- The target set for prevention in Burma in FY08 are quite high as “migrant populations” were included as a MARP in the target setting calculation as well as in the results. This was re-adjusted in the calculation in FY09, resulting in a large variance from FY07–FY09.
- Care and treatment results (palliative care and ART indicators) for Burma in FY08 were not realized as a pilot project was initially included in targeting setting, but not implemented due to programmatic shifts that were made in consultation with USAID.
- Treatment targets and indicators for Burma include “indirect” support through other donors such as 3D Fund and MSF.
- There are no care results for PSI/Lao as the care elements of their program, namely, VCT, began in FY2010.
- As noted in the Thailand chapter of the report, USAID support to PSI/Thailand ended after FY07 therefore there are no results are presented after this time. These results still collected by USAID through the support to Pact and FHI for PSI/Sisters.

A. PSI/Burma

Project Objective	FY07		FY08		FY09	
	Target	Result	Target	Result	Target	Result
Increased access to prevention interventions for MARPs <i>Number of individuals reached through community outreach with promote HIV and AIDS prevention through other prevention</i>	200	250	475000	319323	225000	161682
Increased access to care, support, and treatment for PLHA <i>Number of individuals who received counseling and testing for HIV and received their test results (ALL including TB patients VCT)</i>	–	–	7550	9441	10050	11965

Project Objective	FY07		FY08		FY09	
	Target	Result	Target	Result	Target	Result
<i>Number of individuals provided with HIV-related palliative (including TB/HIV)</i>	37	33	50	0	0	429
<i>Number of individuals receiving antiretroviral therapy</i>	–	–	50	0	50	48

B. PSI/China

Project Objective	FY07		FY08		FY09	
	Target	Result	Target	Result	Target	Result
Increased access to prevention interventions for MARPs <i>Number of individuals reached through community outreach with promote HIV and AIDS prevention through other prevention</i>	350	847	34000	24950	16174	25451
Increased access to care, support, and treatment for PLHA <i>Number of individuals who received counseling and testing for HIV and received their test results (ALL including TB patients VCT)</i>	–	–	120	344	170	291

C. PSI/Lao

Project Objective	FY07		FY08		FY09	
	Target	Result	Target	Result	Target	Result
Increased access to prevention interventions for MARPs <i>Number of individuals reached through community outreach with promote HIV and AIDS prevention through other prevention</i>	2700	2322	21300	20996	23200	25997

D. PSI/Thailand

Project Objective	FY07		FY08		FY09	
	Target	Result	Target	Result	Target	Result
Increased access to prevention interventions for MARPs <i>Number of individuals reached through community outreach with promote HIV and AIDS prevention through other prevention</i>	290	115	–	–	–	–